

SIXTH ANNUAL REPORT ON MEDICARE FOR  
FISCAL YEAR 1972

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COMMUNICATION  
FROM  
SECRETARY, HEALTH, EDUCATION AND WELFARE  
TRANSMITTING

THE SIXTH ANNUAL REPORT ON MEDICARE, COVERING FISCAL YEAR 1972, PURSUANT TO 42 U.S.C. 1395ll(b)



APRIL 3, 1974.— Referred to the Committee on Ways and Means  
and ordered to be printed with illustrations

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U.S. GOVERNMENT PRINTING OFFICE  
WASHINGTON : 1974

31-303 O

Information  
Resource  
Center

LAW 1329



93rd Congress / 1973-1974

6th report (1972)



THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE  
WASHINGTON, D. C. 20201

Honorable Carl Albert  
Speaker of the  
House of Representatives  
Washington, D.C. 20515

Dear Mr. Speaker:

Transmitted herewith is the sixth annual report on Medicare, covering the program's operation during fiscal year 1972. As you know, this report is required by section 1875(b) of the Social Security Act, as amended.

Although H.R. 1, the Social Security Amendments of 1972, seemed virtually certain to be enacted and was expected to effect major changes in both the substance and administrative arrangements for the Medicare program, the only concession which could be made to those impending changes were the various experimental programs which were undertaken. Those programs were designed to test the feasibility of certain of the anticipated changes, ascertain and take measure of some of the administrative problems which might develop, and aid the business of planning for implementation of the new legislation when it was ultimately enacted. Otherwise, administration of the program in fiscal year 1972 continued essentially as it had in preceding years, characterized by our continuing efforts to maintain efficient and economical operations and to devise administrative solutions to problems which emerged.

As you know, H.R. 1 became law shortly after the close of fiscal year 1972. Implementation of its provisions is now a major focus of our activities in the Medicare program.

Sincerely,

Secretary

Enclosure



REPORT ON MEDICARE

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FROM

THE SECRETARY OF HEALTH, EDUCATION, AND  
WELFARE

The Sixth Annual Report on the Operation of the  
Medicare Program, Pursuant to Section 1875(b) of  
the Social Security Act

July 1, 1971 to June 30, 1972



## FOREWORD

At the end of its 6th year of operation, Medicare had become an established and well-accepted mechanism for protecting the aged against the potentially devastating effects of the high cost of serious illness. Through this program many of the barriers to access to quality health care which plagued the Nation's 21 million elderly in the past have been removed. Moreover, the lives of our aged people have been improved by relieving them of much of the severe financial strain of serious illness.

Medicare affects more than just the elderly population. The families of the aged are more secure in the knowledge that a significant portion of the high medical bills of the elderly will be taken care of. And as these families approach retirement age, they know that they will have one less worry--crippling medical care expenses.

Medicare has also affected the entire population through the high standards of care it has demanded from providers. In fiscal year 1972, Medicare stepped up its enforcement of high quality standards. Following announcement of the President's 8-point program to fight the "depressing" nature of some nursing homes, new initiatives were launched to improve evaluation of the quality of care in nursing homes and to identify and correct deficiencies. As a result, there has been greatly improved surveillance and inspection of facilities, and a program of general upgrading was undertaken which is continuing even today.

Evidence of an inflationary trend in 1971 led to the wage-price freeze on August 15, 1971, and the President's Economic Stabilization Program (ESP). For the many aged persons who live on fixed incomes, the effects of inflation can be especially serious. In line with ESP, Medicare put pressure on providers of care to contain prices. Medicare reimbursement of institutional providers was kept down to a 6 percent increase and for noninstitutional providers, such as physicians, it was confined to no more than 2.5 percent. This 2.5 percent limit continued during fiscal 1973 and into fiscal 1974.

The Social Security Amendments of 1972 (Public Law 92-603), enacted shortly after the close of fiscal year 1972, made major changes in the Medicare program and are expected to have far-reaching effects on the financing and delivery of health care in the United States. Of major impact is the provision which expands the program to include 1.7 million disability beneficiaries as well as insured individuals who require hemodialysis or renal transplantation for chronic renal disease.

Another major amendment encourages the use and development of health maintenance organizations (HMO's) by allowing Medicare beneficiaries to enroll in such plans. An HMO is an organization which provides or arranges for comprehensive health services to enrolled individuals under a prepaid group health or other capitation plan. The HMO is considered a more efficient, less costly method of delivering health care. It is expected that Medicare's coverage will encourage the extension of HMO's to the entire population.

Still another significant amendment requires the establishment of Professional Standards Review Organizations. These organizations will be responsible for review of institutional services paid for by Medicare, Medicaid, and maternal and child health programs, to assure that services were medically necessary and provided in accordance with professional standards. This provision will further encourage high quality care and discourage overutilization.

The 1972 Amendments also broaden the authority to experiment with methods of reimbursement aimed at increasing efficiency and economy. The results of this experimentation can be expected to affect the financing mechanisms of the entire health care system. Other provisions are also described in this report.

This 6th annual report on Medicare discusses the program's operations from July 1, 1971, to June 30, 1972. It focuses on Medicare's efforts to improve the quality of care, its administrative problems and solutions, and reimbursement procedures. As Medicare grows older, we can expect it to exert an even greater influence on the Nation's delivery and financing of health care.

# Health Insurance Program

↑ Up } Fiscal Year 1972  
↓ Down } 1972 compared to 1971 unless otherwise noted

## Claims

### Receipts (Millions)

Part A	19.2	↑	7.3%
Part B	54.5	↑	10.0%
Total	73.7	↑	10.0%

### End-of-Year Pendings (Millions)

Part A	.4	↓	4.4%
Part B	2.2	↓	12.3%

### Processing Time (Mean Days)

		Yearly Average	
Part A			
(contractors)	11.6	↓	2.5%
Part B			
(contractors)	20.9	↓	18.4%

## Beneficiaries Covered

as of January 1 (Millions)

	1971	1972
Part A	20.6	21.0
Part B	19.7	20.2

## Payments during 1972

(Millions)

Part A	\$6,109	↑	12.2%
Part B	\$2,255	↑	10.8%

## Providers of Services

—End-of-Year

### Part A

Hospitals	6,743
Skilled Nursing Facilities	4,058
Home Health Agencies	2,222
Total	13,023

### Part B

Physicians	200,000
Laboratories	2,873

## Private Contractors

—End-of-Year

### Part A

Intermediaries	{	Blue Cross	73
		Other Insurance	
		Companies	9
		Subtotal	82

### Part B

Carriers	{	Blue Shield	32
		Other Insurance	
		Companies	15
		Subtotal	47
		Total	129

State Agencies . . . . . 53

## Administrative Costs

### Unit Costs Per Claim

#### Part A

SSA only	\$ 3.98
Intermediary only	4.55

#### Part B

SSA only	0.47
Carrier only	3.20

### Total Administrative Costs

(Millions) . . . . . \$414.6



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## PART I

### IMPROVING THE QUALITY OF CARE IN MEDICARE-CERTIFIED INSTITUTIONS

In remarks at a Joint Conference of the National Retired Teachers Association and the American Association of Retired Persons in June 1971, President Nixon, referring to the "depressing" nature of some nursing homes, said:

"I think we should take notice of this problem. I am confident that our Federal, State and local governments, working together with the private sector, can do much to transform the nursing home--for those who need it, and of course, there are those who do not need or want it--transform it into an inspiring symbol of comfort and hope."

"....One thing you can be sure, I do not believe that Medicaid and Medicare funds should go to substandard nursing homes in this country and subsidize them."

The President followed up his remarks by announcing in August 1971 an 8-point program for action:

1. He ordered expansion of the Federal program for training state nursing home inspectors.
2. He announced his intention to ask the Congress to authorize the Federal government to assume 100 percent of the cost of State inspections of nursing homes.
3. He ordered consolidation of all activities in the Department of Health, Education and Welfare related to the enforcement of nursing home standards, placing enforcement responsibility with a single official who would be accountable for the success or failure of the endeavor.
4. He announced his intention to request funds to enlarge the Federal enforcement program by creating 150 additional positions to enable the Federal Government to more effectively support State efforts to enforce the law and to upgrade nursing homes.
5. He directed this Department to institute short-term training of health workers who are regularly involved in furnishing services to nursing home patients.

6. He directed this Department to assist the states in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual nursing home patients.
7. He directed this Department to undertake a comprehensive review of the use of long-term facilities as well as standards and practices of nursing homes and to recommend further measures which may be needed.
8. He restated his intention that Medicare and Medicaid funds will be cut to those nursing homes that fail to meet reasonable standards.

Much of our effort during fiscal 1972 was directed toward executing the President's directives. As an immediate first step, the Assistant Secretary for Health and Scientific Affairs was given responsibility for coordinating all Departmental activities related to enforcement of nursing home standards. To assist him in this effort, a new Office of Nursing Home Affairs was created which undertook as one of its first tasks a critical examination of existing regulatory activity in the nursing home field in order to develop concrete recommendations for unifying and coordinating the entire effort. The new initiatives launched as a result of the President's directives are reflected in the Medicare program in a number of significant projects which were initiated or expanded during fiscal 1972. Although aimed specifically at improving our ability to evaluate the quality of care in nursing homes and to identify and correct deficiencies, many of those initiatives can be expected to improve the quality of care in all Medicare providers.

#### Increased Inspections of Medicare Facilities

Under contracts with the Social Security Administration, State health departments are required to determine whether institutions wanting to participate in Medicare or to continue their participation meet the program's health and safety requirements and other conditions of participation. SSA evaluates State agency survey findings and recommendations, notifies the institutions of approval or disapproval of their participation, and conducts periodic on-site evaluations of participating facilities and State agencies to assess the effectiveness of the State survey and certification process.

To increase State agency surveillance of health facilities and to assure correction of deficiencies found during State surveys, the total Medicare budget for State agencies was increased from \$14,300,000 in FY 1972 to \$17,900,000 for FY 1973. The increase in

funds was intended to enable the State agencies to increase their staffs of health professionals by about 10 percent nationally and to make more frequent inspections of health facilities.

As reflected in the following table the total number of Medicare State agency visits to health facilities in FY 1973 will be about 47,480 compared to 33,570 in FY 1972, an increase of over 40 percent. A substantial increase in visits to hospitals is due primarily to a change in the resurvey period. From the beginning of the program through FY 1972, hospitals participating in Medicare were resurveyed every 24, 18, or 12 months, depending on the level of certification. Beginning in FY 1973, all hospitals will be surveyed annually.

In FY 1972, there were 3,400 hospital resurveys and about 7,100 "other" hospital visits by Medicare State agencies. We expect about 6,840 hospitals to be resurveyed in FY 1973 and 8,700 "other" visits, an increase of about 50 percent in the State workload. There will also be substantial increases in the number of State agency resurvey and "other" visits for all other providers and suppliers of services.

The State agency visits, other than formal resurveys, consist of announced and unannounced visits to follow-up on the facilities' correction of deficiencies, to investigate complaints against health facilities reported to SSA district offices, and to provide assistance to the facilities in meeting Medicare requirements. We have requested the State agencies to increase their use of unannounced visits to assure that conditions found during scheduled visits are truly representative and not just "window dressing" for the benefit of the State inspectors.

# State Agency Survey and Other Visits

	FY1972 Actual	FY1973 Proposed
1. Hospitals		
Initial Application	120	110
Formal Resurvey	3,400	6,846
Other Visits	7,100	8,700
	<u>10,620</u>	<u>15,656</u>
2. Home Health Agencies		
Initial Application	60	40
Formal Resurvey	1,160	2,315
Other Visits	3,500	6,100
	<u>4,720</u>	<u>8,455</u>
3. Skilled Nursing Facilities		
Initial Application	280	200
Formal Resurvey	4,100	4,380
Other Visits	9,400	10,500
	<u>13,780</u>	<u>15,080</u>
4. Independent Laboratories		
Initial Application	270	200
Formal Resurvey	2,880	3,145
Other Visits	700	4,200
	<u>3,850</u>	<u>7,545</u>
5. Other		
Initial Application	80	30
Formal Resurvey	230	314
Other Visits	290	400
	<u>600</u>	<u>744</u>
6. Totals	33,570	47,480

## Expanded Surveillance of Skilled Nursing Facilities 1/

To increase State agency surveillance of skilled nursing facilities (SNF's) and assure correction of deficiencies found during State surveys, we requested and received a supplemental budget sufficient for the State agencies to increase the number of health professionals by more than 10%. The increased staff will be needed for an estimated 20% increase over 1972 in the number of Medicare SNF visits planned for FY 1973.

### Stepped-up Federal Surveys

Direct Federal surveys of providers are used as a means of assuring that the State agencies are properly performing their survey responsibilities. The findings of federal surveys identify areas where the States need to improve and strengthen their operations. In 1971, Federal surveys were made of about 140 health facilities. By the close of FY 1972, about 200 facilities had undergone Federal survey.

### Follow-up on Correction of Deficiencies

During FY 1972, we instituted new procedures to ensure timely correction of significant deficiencies found in SNF's and hospitals during the course of State surveys. Our goal here is to assure that important deficiencies are generally corrected within 60 days of the State's most recent survey. Longer periods are allowed in only a few situations. If major changes must be made in an institution's physical plant, for example, a longer period could be permitted but only if patient care is adequate and there are no hazards to patient health and safety.

### Termination of Medicare Certification for Certain Facilities

The intent of the increased survey effort is to motivate and help providers to correct deficiencies and upgrade the quality of care. In those situations in which significant deficiencies have continued despite efforts to bring about improvements, we have been obliged to terminate the institutions' agreements to participate in the Medicare program. During fiscal 1972, the Medicare certification of 14 skilled nursing facilities was terminated for failure to meet Medicare's health and safety requirements, and in June, we were in

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1/ Instead of "extended care facilities", the term "skilled nursing facilities" is used throughout this report, in accordance with the requirement of section 278 of the Social Security Amendments of 1972, P.L. 92-603.

terminating certification of seven more facilities. Of greater significance, however, is the fact that as a result of one-day efforts of about 700 State surveyors, hundreds of facilities have substantially improved staff performance, physical environment, and the quality of care they offer.

#### 2.2 District Office Handling of Complaints

In October 1971, SSA began to inform the public that complaints against nursing homes could be filed with local Social Security offices. From then through June 1972, over 2500 complaints were received, about 900 of which involve Medicare facilities. Approximately 70% of the complaints were found to be totally or partially valid. As a result of investigations and subsequent follow-up actions, hundreds of improvements have been made or suggested by the facilities involved.

#### Revision of Skilled Nursing Facility Regulations

Regulations defining many of the health and safety requirements which a skilled nursing facility must meet to participate in Medicare have been revised and were published in October 1971. Keeping with our emphasis on patient care quality, the regulations place much greater stress on how care is rendered in nursing homes. They also contain very specific standards for assuring a safe environment and adequate and qualified medical and paramedical staff.

#### Fire Safety Guidelines

Regulations and guidelines for enforcing the Life Safety Code provisions of the National Fire Protection Association have been issued to the State Health Departments. In most States, sub-agreements have been signed with either the State Fire Marshal or the Hill Burton Agency of the State Health Department to perform the Life Safety Code inspections. A joint Medicare-Medicaid intensive training program for Life Safety Code inspection is planned.

#### Revision of Conditions of Participation for Hospitals, Home Health Agencies and Independent Laboratories

Revision of the Conditions of Participation for Hospitals and Home Health Agencies and the Conditions of Coverage for Independent Laboratories are all expected to be issued soon as proposed regulations. As is the intent of the revised SNF regulations, the hospital and home health revisions are oriented towards more effective assessment of actual patient care. The conditions of coverage for laboratories place emphasis in the area of proficiency testing and

provide for greater coordination with the requirements of the Clinical Laboratories Improvement Act, administered by the Center for Disease Control, leading eventually to joint standards, surveys, and certifications under both programs.

#### Skilled Nursing Facility Demonstration Projects

As a direct result of a SSA-sponsored conference in Boston, we have initiated some demonstration projects to determine the degree of effectiveness in the skilled nursing facility program attainable under current policies with optimum circumstances of understanding and cooperation by providers of services, intermediaries and other program components. The first such projects have been initiated in Massachusetts and Connecticut. Specifically, they seek (1) to test as quickly as possible the validity and relative importance of the more widely heard allegations about the factors that affect the use of skilled nursing facilities; (2) to select some factors which appear to have relatively high impact and which are susceptible to change as a result of direct or indirect action by SSA in cooperation with intermediaries, providers and physicians; (3) to attempt to implement such changes; and (4) to test the results against pre-change performance. Regions have been asked to identify sites where similar demonstration projects might be effectively undertaken.

PART II  
THE WORK OF MEDICARE CONTRACTORS

Much of the day-to-day operational work of the Medicare program is performed by intermediaries (hospital insurance) and carriers (medical insurance) which have administrative responsibility for reviewing claims for benefits and making payments. <sup>1/</sup> Intermediaries and carriers are commercial insurance companies and Blue Cross-Blue Shield plans whose participation in administration of the program was stipulated by the original Medicare legislation. Largely through automated data processing systems, intermediaries processed almost 20 million bills during fiscal 1972 from hospitals and other participating providers of services, and carriers processed over 54 million claims for physicians' and other medical services covered by the supplementary medical insurance program.

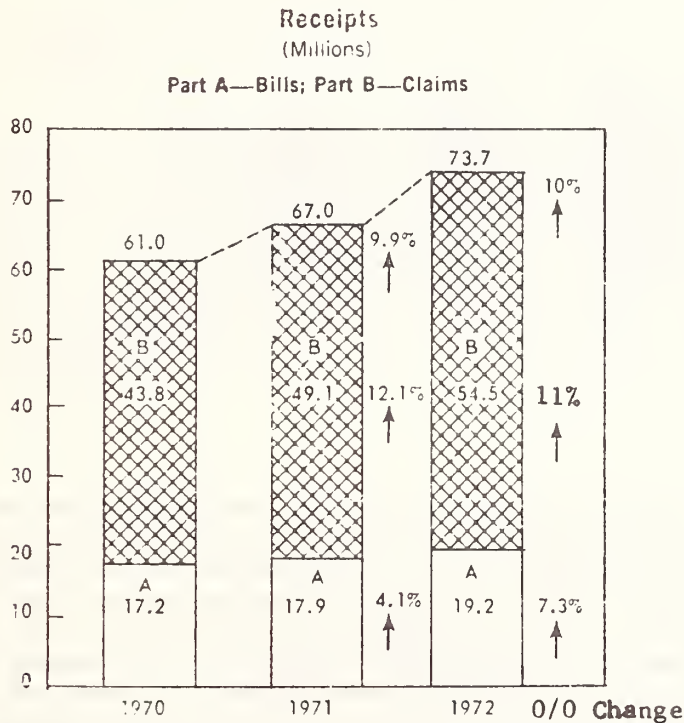
The various workload and financial reports which intermediaries and carriers are required to submit for a reporting period permit the evaluation of their operations and costs required for those operations. Workload reports reflect not only the quantity of work being done but also the timeliness of performance. Quantity of work to be produced is measured in terms of claims awaiting action and the time required to complete them. Promptness is also measured in terms of the number and proportion of cases awaiting action for an unusual length of time (e.g. over 30 days) in relation to total pending cases. Complexity of workload is indicated by the distribution of claims by type, and the number of cases which must be returned for additional information or documentation before payment may be made. The monitoring system provides pertinent data for each intermediary and carrier and permits the computation of national averages for comparison purposes. When significant disparities between individual performance and national averages are identified, necessary corrective action is undertaken.

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<sup>1/</sup> A complete listing of intermediaries and carriers for the Medicare program is in Appendix D.

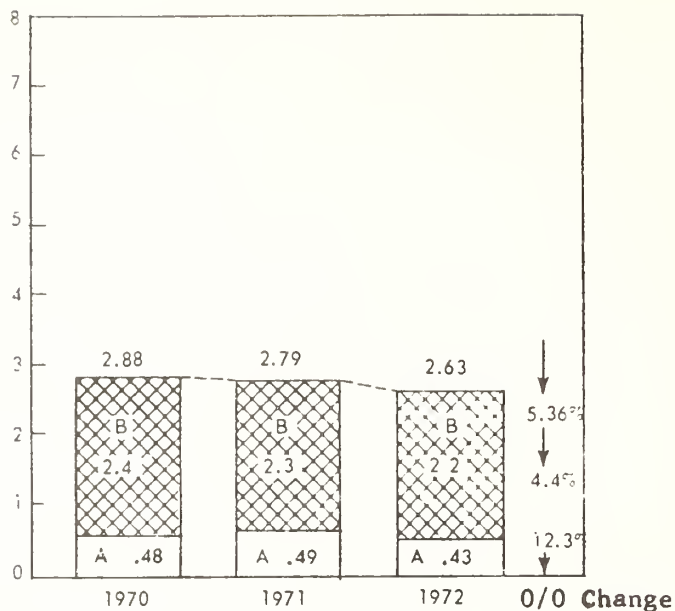
## Claims Workloads and Processing Time

Both Part A bills and Part B claims received in fiscal 1972 continued the upward trend of about 10 percent per year established in previous years. Part A bills were up 7.3 percent to 19.2 million, and Part B claims were up 11 percent to 54.5 million.



The end-of-year pendings showed an impressive overall decrease of 5.36 percent to 2.63 million. Most impressive was the 12.3 percent decrease in Part A bills pending, from 490,000 to 430,000.

**End-of-Year Pensions**  
(Millions)



As indicated in the following table, mean processing time for Part A intermediaries, from the date of receipt of a bill to the date of payment, followed the usual seasonal pattern--decreasing in the first quarter of 1972, increasing significantly in the second quarter, but then leveling off in the third. Average processing time for the year was slightly less than for fiscal 1971. Also, as the following table indicates, the percentage of bills pending over 30 days reflected an overall increase from 15.2 percent in 1971 to 16.3 percent in 1972. The largest increase in the percentage of bills pending over 30 days occurred in the second quarter when the figure rose from 14.6 percent in 1971 to 17.4 percent in 1972.

### Part A

Quarter	Contractor Processing Time (Mean days)		Percentage of Bills Pending Over 30 Days	
	1971	1972	1971	1972
1	13.0	11.4	16.6	15.9
2	11.9	12.7	14.6	17.4
3	12.0	12.1	15.1	16.0
4	10.9	10.3	14.6	15.8
Yearly Average	11.9	11.6	15.2	16.3

Average processing time for Part B bills (see table following) decreased significantly during 1972, contributing to a parallel reduction in the percentage of aged claims. This overall improvement in the timeliness of processing was largely attributable to the more extensive and effective utilization of automated systems in Part B claims processing by carriers as well as their increased experience in performing their Medicare functions.

### Part B

Quarter	Contractor Processing Time (Days)		Percentage of Claims Pending Over 30 Days	
	1971	1972	1971	1972
1	26.1	21.9	28.7	23.4
2	23.4	19.4	25.5	18.1
3	27.8	22.4	27.2	20.2
4	25.0	19.8	23.5	17.4
Yearly Average	25.6	20.9	26.2	19.8

## Contractor Evaluation and Performance Standards

We have been developing qualitative and quantitative standards for Medicare contractor performance. As an initial step, we have developed, in cooperation with representatives of the contractors, a methodology for objectively measuring and evaluating contractor performance. The effort was concentrated upon the refinement of quantitative measures. The three primary measures of contractor performance--cost, timeliness and quality--are being adjusted, as a result, to take into account certain noncontrollable variables in order to produce a more equitable basis for evaluation.

We are now developing criteria for evaluating aspects of contractor operations which reflect the quality of performance. This would include such matters as relations with beneficiaries, doctors and other professional people, providers and suppliers; program utilization safeguards; program inquiries and correspondence; the appeals process; timeliness and accuracy of required reports; and responsiveness to required program changes. Our future effort will be directed toward establishing operational standards, that is, minimum standards which a contractor must meet in order to continue in the program.

We are also exploring the feasibility of using incentive reimbursement mechanisms to obtain improvements in contractor performance. <sup>2/</sup> Multiple incentive contracts in general government use are being examined to determine whether they can appropriately and effectively be tailored to the contractor performance requirements of the Medicare program.

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<sup>2/</sup> Section 222(b)(1) of P.L. 92-603 authorizes experiments and demonstration projects to determine whether incentive contracts will improve the performance of Medicare contractors.

## Renegotiation of Carrier and Intermediary Agreements

In December 1971, each carrier and intermediary was advised that the agreements which were to expire June 30, 1972, would not be renewed in their existing form. This action was taken because it was recognized that additional controls were needed to strengthen and clarify parts of the agreements dealing with the Secretary's right to full use and access to contractor and subcontractor program data, the right to examine the financial records of contractors and subcontractors, and the right of the Secretary to require prior approval for designated subcontracts and leases. In addition to the clarification of existing contract sections, the addition of new sections to the contracts concerning other areas was also proposed.

Related to these contractual revisions was legislation which was then pending which would, in most instances, either have defined the limits of some of these revisions or else buttressed our contractual objectives.<sup>3/</sup>

### Claims Processing Systems

#### Part A Model Systems

SSA continued in 1972 to monitor the development of two Model Systems for processing Part A claims: one being developed by the Blue Cross Association (BCA), for its member Plans; the other being developed by Aetna Life Insurance Society of America for commercial intermediaries.

Although both systems automate the entire claims process, they were designed to accommodate different requirements of potential users. The Blue Cross system consists of a number of programs that can be used by member Plans with small scale computer equipment. Plans that use large-scale equipment could also utilize the system in a multi-processing environment. Since most commercial users have large-scale computer equipment, the Aetna system consists mostly of large integrated programs that can be operated either at the user's field location or at a centralized location using central processing concepts.

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<sup>3/</sup> Medicare intermediary and carrier contracts which became effective on July 1, 1973, incorporate the added controls mentioned in this section and changes made necessary by enactment of P.L. 92-603.

In 1972, BCA decided to adopt the regional concept which adds multi-Plan processing capability to the BCA system. This makes it possible for a number of Blue Cross Plans to be tied together in a single EDP processing operation. In conjunction with this new trend of operating, BCA plans to redesign the system for large-scale computer hardware in 1973.

During 1972, the Blue Cross system was in use for eight Plan locations, with two of the Plans operating on a multi-Plan basis. Six other Plan locations were in some stage of implementing the system and 23 additional locations were identified for implementation during 1973. The Aetna system became operational at Aetna's Hartford field office on April 3, 1972, and is scheduled for implementation in 17 locations in 1973.

During the course of the year, SSA also began to explore the feasibility of an amalgamated Part A system which combines all features required by current potential users of both model Systems and incorporates any additional features unique to independent Part A system's needs such as the Los Angeles Plan and SSA's direct reimbursement activity. An announcement was published in Commerce Business Daily soliciting qualified software firms, interested in contracting, to analyze the different systems and to determine the most efficient means of obtaining a single Part A Model System.

#### Part B Model System

During the year, the Part B Model System was installed in five additional carrier locations, bringing the total number of users to 16. We also successfully installed a multi-State version of the system which allows processing of data for more than one carrier simultaneously. This opened the possibility of using regional data centers to process claims for several carriers.

During the year, SSA also completed and installed a new module which greatly simplified the bookkeeping required by the system. This "Reconciliation Module" keeps track of all overpayments, underpayments, check records, and payment records to allow the carrier to balance its books properly.

## Procedural and Systems Improvements

Use of Optical Character Recognition (OCR) Equipment to Reduce Contractor Costs. Machines capable of reading typewritten or printed characters have been on the market for about fifteen years. Since about the mid-1960's, SSA has used an optical character reader to read typewritten employer earnings reports. In 1972, SSA, together with the Pan American Life Insurance Company, developed a prototype OCR application for the Part B Model System. A special coding form was developed which allowed the direct conversion of handwritten coding to magnetic tape. This innovation resulted in net savings of about \$5,000 a month.

Development of Standard Hospital Billing Form. Working with the American Hospital Association, the Blue Cross Association, and the commercial insurance industry, we have developed a prototype hospital billing form which can be used nationwide to replace all existing insurance billing forms. If the field tests of the form prove that it can feasibly be used, we expect significant decreases in hospital insurance billing costs.

Beneficiary Listing Furnished States. The Carrier Alphabetic State microfilm (CAST), an alphabetical listing by State of all persons eligible for Medicare was designed to help carriers locate missing Medicare numbers on medical bills. During 1972, CAST was given to selected State welfare agencies on an experimental basis as an aid in finding correct social security numbers of persons eligible for buy-in coverage. This further application of CAST proved so successful that it has been made available to other States to help them improve their overall buy-in operations. Requests for CAST have been received from 46 of the 49 buy-in States.

New Beneficiary Denial Notice Procedures. Before 1972, intermediaries notified a beneficiary if a bill was denied in its entirety. If the bill was only partially denied, notice of the partial denial was sent by the Social Security Administration at a much later point in the bill processing system. Under new procedures instituted in 1972, all beneficiary denial notices, whether total or partial, are sent by the intermediaries at the time the denial decision is made. Beneficiaries now receive denial notices as much as three months earlier than under the old method.

## Cost of Contractors' Medicare Operations

Control of the costs of intermediary and carrier operations is achieved in part through the budget process. Annual and quarterly claims workload estimates form the core of the budgeting process. In addition to the costs involved in claims processing, intermediaries and carriers have costs related to their other responsibilities which do not lend themselves so readily to precise measurement. These include provider and professional relations, utilization review, beneficiary services, and, the most important from a cost standpoint, audits of providers.

Intermediaries and carriers are required to submit detailed justifications with their annual budget estimates which sufficiently explain the proposed use of funds requested. Items of possible expenditure must be explained fully and are considered in the light of estimated workloads and productivity.

When budget analysis is completed, intermediaries and carriers are granted annual budget approvals which are apportioned on a quarterly basis. They are required to plan their operations within these annual and quarterly allocations and are not permitted to incur expenses in excess of them without written authorization.

Under the cost reporting system, each intermediary and carrier is required to submit quarterly cost statements and final annual cost reports based on its accounting year. The quarterly reports reflect actual administrative costs distributed functionally. In addition, they report total benefits paid and workloads processed during the period. These are reviewed in relation to such factors as manpower use, productivity, cost per claim, and the ratio of administrative costs to benefit payments. Significant deviations of incurred cost from the approved budget must be explained.

Final cost reports form the basis for audit and final cost settlement each year and are, therefore, submitted in greater detail. All of the information contained in the quarterly reports is included in these annual reports and, in addition, a detailed justification of proposed expenditures much like that required for budget estimates must be submitted. All pertinent information which has been accumulated about each intermediary and carrier becomes part of the contract reporting and monitoring system used to coordinate the entire system.

Administrative costs for Part A intermediaries increased from \$99,869,800 in 1971 to \$110,128,500 in 1972. These figures included provider audit costs of \$26,989,100 in 1971, and \$31,386,700 in 1972. The \$4.4 million increase in provider audit costs accounted for 43 percent of the increase in administrative costs. The remainder was attributable to salary and other price increases, a 5.7 percent workload increase, continuing emphasis on quality review and implementation of new data processing systems.<sup>4/</sup>

Administrative costs of Part B carriers increased from \$159,890,500 in 1971, to \$171,765,600 in 1972.<sup>5/</sup> The cost increase was due to large workloads, salary and other price increases, improved claims review processes, and implementation of new processing systems. Intensified efforts to improve claims are expected to effect savings in benefit payment and, therefore, effect overall reductions in total program costs.

Total administrative costs for 1972 were quite reasonable when measured as a percentage of benefit payments. The ratio of administrative costs to benefit payments for Part B exceeds the same ratio for Part A because of the large volume of claims involving relatively small payment amounts in the medical insurance program.

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<sup>4/</sup> Administrative costs for Part A intermediaries for fiscal year 1973 were estimated as \$123,071,800, including \$31,571,800 in provider audit costs.

<sup>5/</sup> Fiscal year 1973 costs have been estimated to be \$186,600,000.

## Reduction of Medicare Bank Balances

During 1972, Medicare carriers and intermediaries were urged to minimize bank balances which they maintain in special bank accounts established to cover checks issued for reimbursement under hospital and supplementary medical insurance. As of December 31, 1972, those balances had been reduced to \$116 million from a level of \$146 million in December 1970. During the same two-year period, on the other hand, the level of benefits paid under the Medicare program increased about 22 percent. As a result of the methods being used to control the bank float, we estimate that the Hospital Insurance and Supplementary Medical Insurance Trust Funds are now realizing savings of over \$3 million per year. Further savings are anticipated as more experience is gained with these new techniques.

## Monitoring Provider Cost Report Processing

An automated system has been developed to furnish more complete and timely data on the progress of intermediaries in obtaining and processing to final settlement provider cost reports. The system places emphasis on each stage in the processing cycle and focuses efforts on the movement of cost reports through each processing step. The system will contain a mechanism for workflow control, audit cost control, and cost effectiveness analysis, and it is expected to provide both intermediaries and the Government with financial and statistical data for more effective management of the entire audit process. It should also provide controls on contractor audit subcontracting activity and expenditures and should enable us to evaluate and compare intermediary performance in carrying out audit responsibilities.

## Banking Medicare Funds in Minority Banks

Early in 1969 the President issued an Executive Order encouraging all federal agencies to deposit federal funds in minority-owned banks whenever possible. A Government-wide goal of \$35 million average daily balance was established of which this Department was assigned \$10 million. Through numerous meetings with Treasury officials, minority bankers, Medicare contractors and others, we succeeded by the close of fiscal 1972 in getting intermediaries and carriers for the Medicare program to maintain \$9 million as an average daily balance among 14 minority-owned banks in 12 states.<sup>6/</sup>

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<sup>6/</sup> As of June 30, 1973, intermediaries and carriers had an average daily balance of \$14 million on deposit in 15 minority-owned banks in 14 states, well exceeding the DHEW goal.

## PART III

### DIRECT REIMBURSEMENT

Some 649 hospitals, skilled nursing facilities and other providers of services are not served by the Blue Cross plans and commercial insurance companies which function as intermediaries for the Medicare program but have elected to be reimbursed directly by the Government. This represents an increase of 69 direct-dealing providers from the 580 in 1967. Nationally, direct-dealing providers represent about three percent of all participating providers. They are dispersed among 35 States, the District of Columbia and Puerto Rico and include all kinds of health care facilities. Approximately 80 percent are State or municipally controlled. In addition, 418 Department of Defense, Public Health Service and Veterans Administration hospitals, participating as Federal emergency hospitals, deal directly.

The direct-dealing workload multiplied more than ten times from 116,000 bills during 1969 to 1,293,000 during 1972. Workload increases made it necessary to convert from a manual claims processing operation to an automated system. This has permitted the growing direct-dealing workload to be processed with a limited increase in personnel.

In addition to its intermediary responsibilities, SSA serves as the Part B carrier for eight State hospital systems, Saint Elizabeth's Hospital in Washington, D.C., the New York City Hospital system, two Pennsylvania tuberculosis hospitals, and the Federal emergency hospitals. It also handles Part B reimbursement for 30 group practice prepayment plans that have elected to deal directly with the Government.

Direct-Dealing Providers

Kind of Provider	State/Municipal	Other	Total
Hospital	173	33	206
SNF	13	65	78
HHA	349	12	361 <u>1/</u>
Physical Therapy	0	4	4
Total	535	114	649
Federal Emergency Hospitals	418	0	418
Grand Total	953	114	1,067

1/ Includes 312 HHA units reporting to a central office which file consolidated cost reports so that only 49 consolidated cost reports are filed.

# Direct Reimbursement Claims Processing

<u>FY</u>	<u>Bills Processed</u>	<u>Benefits Paid</u>
1967	116,237	\$ 39.5 million
1968	297,607	69.1 million
1969	492,595	110.3 million
1970	382,640	94.6 million
1971	696,137	104.8 million
1972	1,293,587	102.0 million

Approximately 1.5 percent of the national Part A claims processing workload was generated by direct-dealing providers, ranking the direct-dealing operation fourteenth among some 160 intermediary processing centers.

## Relative Workloads Prior to FY 1972

<u>Ranking</u>	<u>Intermediary</u>	<u>Percent of Part A National Workload</u>
1.	Illinois-Chicago Blue Cross	5.1 <u>2/</u>
10.	Indiana Blue Cross	2.3
11.	North Carolina Blue Cross	1.9
12.	Pennsylvania-Intercounty	1.8
13.	Kentucky Blue Cross	1.7
14.	<u>Division of Direct Reimbursement</u>	1.5 <u>3/</u>
14.	New Jersey Blue Cross	1.5
15.	Tennessee-Chattanooga Blue Cross	1.4
16.	Alabama Blue Cross	1.3
16.	Maryland-Baltimore Blue Cross	1.3
17.	Iowa-Des Moines Blue Cross	1.2
17.	Washington-Seattle Blue Cross	1.2

2/ Largest intermediary in the country.

3/ Represents Part A workload only; however, the direct-dealing Part A claims workload only accounts for approximately 60 percent of the total claims it processes. The balance of 40 percent represents the processing of Part B claims for provider-based physicians' services.

## PART IV

### PROVIDER REIMBURSEMENT

Reimbursement of participating hospitals, skilled nursing facilities, home health agencies and other providers is required by law to be based on the "reasonable costs" of furnishing covered services to Medicare beneficiaries. Reasonable cost reimbursement is intended generally to meet the actual costs incurred by a provider in rendering patient care, taking into account those differences in provider size, level of care, scope and utilization of services, geographic location and other factors which may cause actual costs of delivering patient care to vary among individual providers. Increases in actual costs are reflected, of course, in increases in Medicare reasonable cost reimbursement, provided such costs are not out of line with the costs of similar providers.

As health care costs continued to increase during Medicare's sixth year of operation, so too did the concern that reimbursement on the basis of incurred costs may not contain adequate incentives for provider efficiency and economy. Although reimbursement of incurred costs is subject to the limitation that such costs be reasonable and not substantially out of line with the costs of comparable providers in the same area, this limitation has been difficult to apply effectively. Moreover, the disallowance of costs after they have been incurred creates financial uncertainty for providers with resulting problems in administrative planning.

Solutions to the basic problems of a reimbursement mechanism which is geared to providers' actual costs and determined retrospectively are of a kind that require specific legislative authority. H.R. 1, the then proposed Social Security Amendments, under consideration by the Congress throughout fiscal 1972, contained provisions addressed to some aspects of this problem.<sup>1/</sup> Some temporary restraint on Medicare reimbursement to providers was introduced by the President's economic stabilization program.

#### The President's Economic Stabilization Program

In August 1971, the President announced Phase I of his Economic Stabilization Program, an immediate 90-day freeze on prices, wages,

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<sup>1/</sup> H.R. 1 was passed by the Congress and signed into law by the President on October 30, 1972. The provisions of the new law (P.L. 92-603), including those addressed to provider reimbursement problems are outlined in Appendix C.

salaries, and rents and the creation of a Cost of Living Council (CLC) to administer the freeze and advise on further stabilization policies and actions. Phase II began in November 1971 and in December the CLC promulgated price control regulations for the health care industry:

(1) Institutional providers, such as hospitals and nursing homes, were permitted only such price increases as were justified by allowable costs adjusted for productivity gains. A provider was permitted to increase its prices over the base prices and thereby increase its aggregate annual revenue up to 2.5 percent without previous approval. Increases from 2.5 to 6.0 percent in aggregate annual income had to be reported to the Internal Revenue Service with supporting justification and to the appropriate Medicare intermediary. Increases above 6.0 percent required that an exception be granted by the Price Commission.

(2) Noninstitutional providers, such as free-standing home health agencies and outpatient physical therapy providers and including physicians, were permitted aggregate increases in their prices, based on allowable cost increases, of no more than 2.5 percent a year. For-profit providers could not increase their profit margins above the average of the highest two of the past three years. Nonprofit providers were not permitted to increase the ratio of their net revenues to their total revenues compared with the base-year average.<sup>2/</sup>

#### Implementation of the Economic Stabilization Program

Instructions which we issued in May 1972 to implement the Phase II economic stabilization policies with regard to Medicare reasonable cost reimbursement to providers provide that Medicare reimbursement on a per unit-of-service basis for services rendered on or after January 1, 1972, may not exceed the reimbursement payable for the preceding reporting period by more than 6 percent for institutional providers or 2.5 percent for noninstitutional providers, adjusted by a factor of up to 3 percent to recognize increases in the intensity of services provided.

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<sup>2/</sup> The period of mandatory controls ended January 11, 1973, when Phase III of the Economic Stabilization program was announced. Mandatory wage and price controls were abolished except for problem areas in the economy such as the health care industry. To administer Phase III, a Cabinet-level CLC was appointed and an advisory committee of private citizens was established to advise the CLC in the health area.

## Administrative Innovations in Provider Reimbursement Policy

During fiscal 1972, we continued to take administrative steps to refine Medicare policies and procedures governing provider reimbursement in an effort to obtain better cost reimbursement determinations. The following were among the more significant steps taken.

### Apportionment Methods

From the beginning of the Medicare program, providers were able to select between two methods of reimbursement--the Departmental Method and the less-complex Combination Method. Various studies indicated that providers had an advantage in reimbursement based on selection between the two methods, not necessarily justified on merit. To eliminate this option and to require larger institutions to use the method resulting in better cost reimbursement determinations, an amendment to the regulations was published (May 20, 1973) which (1) requires the use of the Combination Method of apportionment for all skilled nursing facilities and for hospitals having less than 100 beds, (2) requires the use of the Departmental Methods of apportionment by all other hospitals, (3) revises the Departmental Method to require apportionment of routine service costs on an average cost per diem basis, (4) provides for separate average cost per diem apportionment of the intensive care units, coronary care units, and other special care inpatient hospital units, (5) specifically provides for the nonrecognition of the cost of luxury items or services, (6) excludes delivery room costs under the Combination Method as well as the Departmental Method, and (7) provides for simplified cost-finding procedures for providers required to use the Combination Method. The revisions are effective for provider cost reporting periods beginning after December 31, 1971. It is anticipated these revisions will result in substantial program savings.

### Provider Recordkeeping Capability and Fiscal Responsibility

In some instances providers entered the Medicare program without adequate records which made it difficult to prepare accurate cost reports and to determine reasonable cost. To protect the program against these situations, proposed amendments to the regulations related to the recordkeeping capability of Medicare providers were published during fiscal 1972. <sup>3/</sup> The proposed amendments provide that (1) an intermediary shall determine whether a newly certified provider has adequate recordkeeping capability for determining the cost of services furnished program beneficiaries before making payments to the provider, (2) an intermediary shall suspend Medicare payments at any time it ascertains that a provider's records are no longer adequate, and (3) the Secretary shall not enter into an agreement for participation in the Medicare program with an organization which has been adjudged insolvent or bankrupt under appropriate State or Federal law or with respect to which a court proceeding to make such judgment is pending.

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<sup>3/</sup> Final regulations were published in the Federal Register on March 9, 1973.

### Accelerated Payments

Final regulations were published (September 18, 1971) establishing the basis for making accelerated payments to providers of services and reflecting the current policies and procedures for computing the amount of and for recovering such payments. The regulations provide that an accelerated payment may be made upon request where a provider is experiencing financial difficulties due to intermediary delay in making payments or, in exceptional situations, where the provider has temporarily delayed submitting bills beyond its usual billing cycle. As a safeguard, provision was made for prior approval of accelerated payments by both the intermediary and the Social Security Administration.

### SNF Interim Rates

Because of the frequency with which overpayments resulted from interim rates of reimbursement for skilled nursing facilities which were based on a percentage of billed charges, instructions were issued (September 1971) requiring all interim reimbursement to SNF's to be made on an average per diem basis for covered Part A inpatient routine and ancillary services.

### Depreciation of Assets

An amendment to the regulations was published on March 4, 1972, placing limitations on the basis for determining depreciation on assets transferred from one governmental entity to another or used under the program by one provider and then donated to another.

### Provider Cost Report Filing Requirements

Instructions establishing provider filing requirements for cost reports were published as proposed regulations during fiscal 1972. <sup>4/</sup> The regulations require providers to file cost reports on or before the last day of the third month following the close of the period covered by the report and establish a 30-day extension for good cause. A provider which voluntarily or involuntarily ceases to participate in the program or experiences a change of ownership is required to file a cost report no later than 45 days after the official date of termination or change of ownership.

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<sup>4/</sup> Final regulations were published in the Federal Register on October 13, 1972.

## PART V

### REIMBURSEMENT FOR PHYSICIANS' SERVICES

Physicians' services are reimbursed under Part B of Medicare on the basis of reasonable charges determined by taking into consideration a physicians's customary charges for a given service and prevailing charges among physicians in the area for the same service. Prevailing charges set the outer limit on Medicare reasonable charge reimbursement subject only to the further limitation that reasonable charges may not exceed the charges applicable under comparable circumstances to the policyholders and subscribers of the carrier for comparable services.<sup>1/</sup> To a great extent, therefore, Medicare reasonable charge reimbursement is responsive to the fee-charging patterns of the medical community.

Previously initiated efforts to achieve greater uniformity in the application of the reasonable charge criteria were continued throughout fiscal year 1972. Beginning in 1971 all carriers have been required (1) to use charge data derived from the immediately preceding calendar year when they update their fee screens for a new fiscal year; (2) to use the median of a physician's charges for a service as his customary charge for that service; and (3) to calculate the 75th percentile of the customary charges in the locality as the prevailing charge ceiling for a given service.

In fiscal year 1972 the percentage of Part B claims on which physicians accepted assignments (excluding hospital-based physicians) was 56.4 percent, the percentage of approved claims on which charges were reduced increased to 46.6 percent, and total charge reductions on approved claims increased to \$362 million (see appendix A, pages 49-50).

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<sup>1/</sup> The 1972 amendments to the Social Security Act (P.L. 92-603) provide that for bills submitted after December 31, 1970, prevailing charge levels may not exceed the 75th percentile of customary charges in a locality for similar services during the calendar year prior to the start of the fiscal year in which the bill is submitted. For fiscal years beginning July 1, 1973, and thereafter, the prevailing charge levels recognized for a locality may not be increased in the aggregate over the previous fiscal year's prevailing charge levels, except to the extent justified by economic indexes reflecting changes in costs of practice of physicians and in earnings levels. For medical supplies, equipment and services furnished after December 31, 1972, which in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such supplies, equipment and services are widely and consistently available in a locality.

## Implementation of President's Economic Stabilization Program

Instructions were issued to the Medicare carriers and put into effect to implement both Phase I and Phase II of the President's economic stabilization program. No increases in screens were allowed during Phase I of the program. With respect to Phase II, the Price Commission advised the Department that the Medicare fee screens in effect on November 13, 1971, should be considered as the base price of recognized "reasonable charges" under the Medicare program and that these fee screens should not be increased by more than 2.5 percent in the aggregate during fiscal year 1973.

If the fee screens had been calculated on the basis of the charges made by physicians during calendar year 1971, without modification, the charges allowed under the Medicare program would have risen approximately 6.2 percent in the aggregate during fiscal year 1973. Therefore, to implement the Price Commission's ruling, instructions provide that only 40 percent (2.5 is about 40 percent of 6.2) of the increases that would ordinarily have been allowed could be recognized in calculating reasonable charges for the new fiscal year. The instructions also provide that where it has come to a carrier's attention that a 1971 charge reflects a price increase that was made contrary to the Phase I guidelines or Phase II regulations of the Price Commission, the charge may not be used in calculating the new fee screens. Further, where a carrier becomes aware of fee increases that appear to violate the limitations on price increases, it will report them to the Internal Revenue Service.

## Procedural Terminology and Coding

The Department initiated a project designed to encourage development of a uniform system of procedural terminology and coding acceptable to the major users of such systems in the health care and insurance fields. The goal was to achieve uniformity in procedural terminology and coding for the various health care related programs of the Department and to provide a uniform national health data base. Pending development and testing of a new terminology and coding system, Medicare carriers were instructed to make no significant changes in the procedural terminology and coding systems now being used in their Medicare operations.

## Review of Provider-Based Physician Reimbursement

During the year a workgroup was formed to study the problems of reimbursement for services of provider-based physicians.<sup>2/</sup> This group was chaired by SSA and consisted of representatives of intermediaries and carriers. Because reimbursement for the services of provider-based physicians comes from both the Part A and Part B trust funds, the administration of this area of reimbursement has been particularly complex and subject to misunderstandings. The workgroup made recommendations on simplified approaches to Medicare reimbursement for the services of these physicians.

### Provider-Based Physicians - Retroactive Adjustments

Instructions were issued to intermediaries and carriers regarding retroactive adjustments in a provider's cost reports where Medicare payments for the services of provider-based physicians have been either more or less than the correct Medicare share of the compensation the physicians receive from the provider. In many instances the charges for the physician services shown on Medicare claims (form SSA-1554) are based on estimates of the expected total departmental charges, and on the estimated time the physician will spend in rendering Part A and Part B services. While the charges for the physician services on Forms SSA-1554 are intended to yield in the aggregate the Part B portion of the physician's compensation, because of the estimating process the amount actually reimbursed may result in an overpayment or underpayment. The instructions issued during the year clarify the Part A intermediaries' responsibility to make appropriate adjustments in the provider cost reports to more accurately represent the Medicare portion of the physician's compensation.

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<sup>2/</sup> The group concluded its deliberations in 1973.

PART VI  
BENEFICIARY APPEALS

Section 1869 of the Medicare law provides appeal rights for a beneficiary who is dissatisfied with the determination of his entitlement under Part A, his enrollment under Part B, or the amount of benefits due him under Part A. Any beneficiary who questions the initial determination made on his hospital insurance claim may request that the decision be reconsidered. If he is not satisfied with the reconsideration decision and the amount in question is at least \$100, he may request a hearing before an Administrative Law Judge of SSA's Bureau of Hearings and Appeals and a subsequent review by the Appeals Council. After exhausting these administrative appeals mechanisms, a claimant may seek judicial review if the amount in question is at least \$1,000.

In the medical insurance program, the entire appeals process is handled by the carrier. A beneficiary who questions an adverse initial decision made by a carrier may ask an informal review of his claim, and if the result of that review does not satisfy him, he may request a formal hearing by the carrier's hearing officer.<sup>1/</sup> The law provides for no appeal from the carrier's decisions to SSA or to the courts.

The reconsideration of hospital insurance claims was being conducted by a specially trained staff in SSA's Bureau of Health Insurance. During fiscal 1972, however, we conducted a pilot project in which five intermediaries conducted the reconsiderations and decided, as a result of that project that we would avoid considerable duplication of effort and improve the speed of processing reconsiderations if they were handled by the intermediaries.<sup>2/</sup>

Beneficiary appeals under both the hospital and medical insurance programs have been increasing at a substantial rate since the program began. Although the volume of appeals processed has risen sharply over the last several years, appeals pending have also increased. Part A reconsideration requests received during fiscal 1972 numbered 31,156, a 17 percent increase over the 26,624 received during 1971. There were 12,273 Part A reconsiderations pending at the years end. The reversal rate was about 12 percent. Under Part B, there

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<sup>1/</sup> Effective with respect to hearings requested after the date of enactment, October 30, 1972, section 262 of Public Law 92-603 requires that an enrollee (or physician or supplier taking an assignment) who is dissatisfied with the determination or the promptness of action on a medical insurance claim, may file for a fair hearing only if the amount at issue is \$100 or more.

<sup>2/</sup> The transfer of the reconsideration function became effective February 12, 1973. After this transfer, SSA assumed responsibility for reviewing a selected sample of completed reconsideration cases, and information gathered from this process is coupled with workload and manpower information in evaluating intermediary performances.

were 553,952 requests for review, a 31.2 percent increase over 1971. Pending at the year's end were 22,140 cases, 16.7 percent less than at the close of 1971. The reversal rate for Part B reviews is about 50 percent.

Requests for Part A hearings received during fiscal 1972 increased to 6,151, a 40 percent increase over 1971. Hearings pending as of June 30, 1972, were 3,704, 56 percent more than at the end of the preceding year. The reversal rate was 45 percent.

During the past 4 fiscal years, the Appeals Council has reviewed an increasing number of administrative law judges' decisions (formerly called hearing examiners). The number in fiscal 1969 was 130; in fiscal 1970, 373; in fiscal 1971, 702; and in fiscal 1972, 1034.

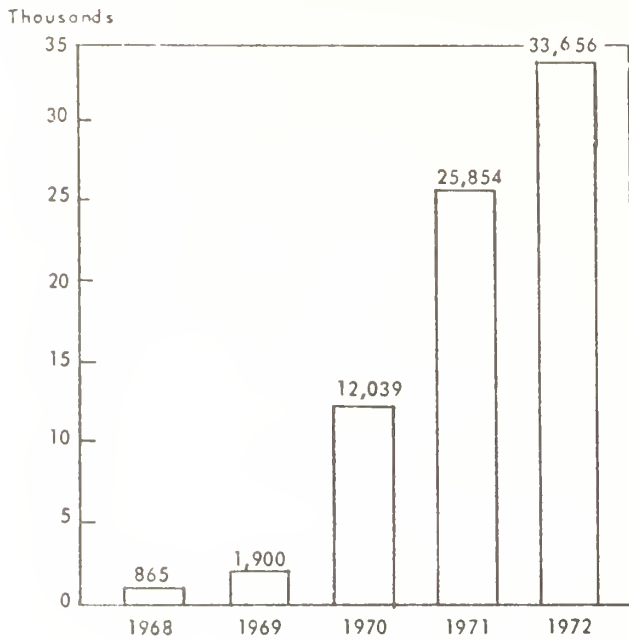
Requests for Part B hearings received during fiscal 1972 increased to 7,972, a 66.5 percent increase over 1971. Hearings pending as of June 30, 1972, were 2,937, 44.4 percent more than at the end of the preceding year.

Of all requests for Part B fair hearings processed, the reversal rate was 22 percent. Included in the total figure for requests, however, was a number of dismissals and withdrawals for which statistics were not kept, so that an accurate reversal rate would be somewhat higher.

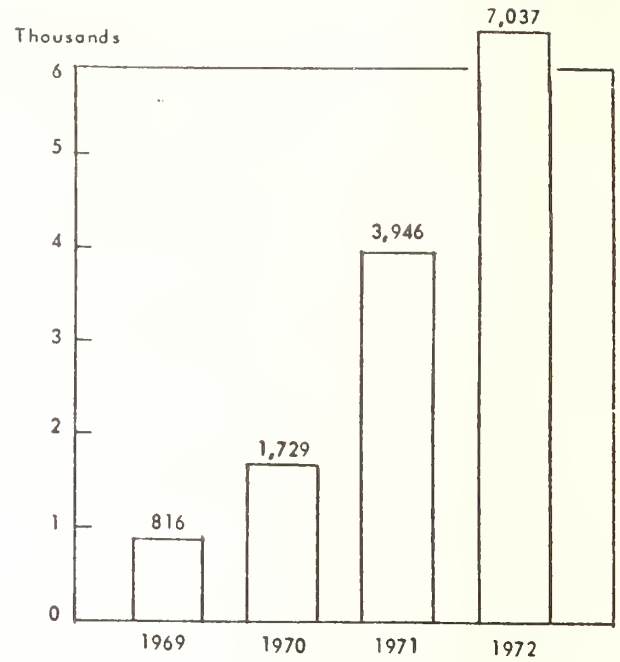
Performance of some carriers in the appeals area is less than satisfactory. We have noted both procedural due process deficiencies and questionable decisions, and we have increased our emphasis on improving the quality of the review and hearing process.

Beneficiary litigation has increased rather significantly in recent months as issues have become more sharply drawn and more sophisticated. Looking to the last three half-years, we see that new filings were received at an increasingly rapid rate. There were 40 court cases filed during the half year ending December 31, 1971; 48 during the half year ending June 30, 1972 (a 20 percent increase); and 93 during the half year ending December 31, 1972 (a 94 percent increase).

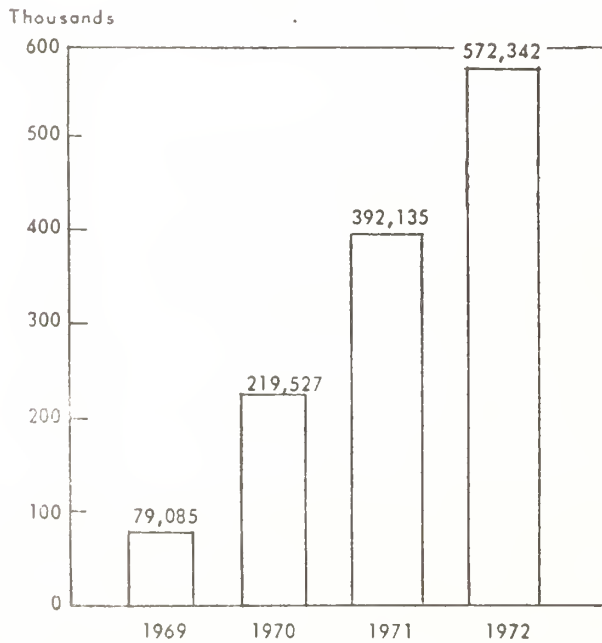
**Part A Reconsideration Cases Processed**



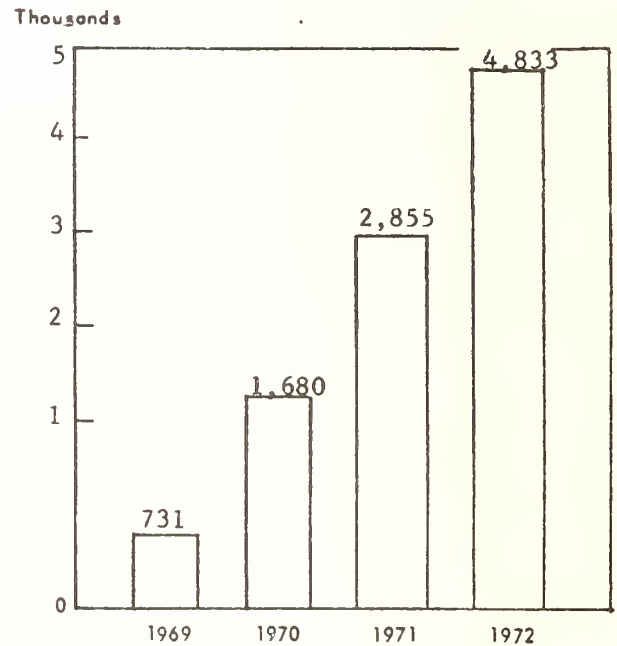
**Part B Hearings Processed**



**Part B Reviews Processed**



**PART A HEARINGS PROCESSED**



## PART VII

### 1/ FRAUD AND ABUSE INVESTIGATIONS

The Department has continued its efforts to prevent fraud and abuse in the Medicare program to the fullest extent possible and to improve its mechanisms for detecting and investigating situations in which there is evidence of fraud or abuse. Departmental policy requires development of every case of suspected fraud or abuse to the point that suspicion is removed or the evidence shows that some violations did occur. Although a greater number of cases of suspected fraud and abuse were received in 1972 than 1971, this is not believed to have been the result of a greater incidence of attempted fraud or abuse. Rather, the increased number of cases was due to: (1) greater experience and familiarity of investigators both for the Department and for intermediaries and carriers in detection and prevention techniques; (2) publicity regarding activities of this Department and the Department of Justice in gaining indictments and convictions; and (3) greater familiarity of beneficiaries with Medicare provisions and their resulting increased awareness of improper charges.

#### 2/

#### Medicare Fraud and Abuse Workloads for Calendar Years 1971 and 1972

	1971	1972	Increase	Percent of Increase
TOTAL RECEIPTS	6,440	8,136	1,696	26
FRAUD	2,540	3,280	740	29
ABUSE	3,900	4,856	956	25
TOTAL CLEARANCES	5,819	7,048	1,229	21
FRAUD	2,252	2,831	579	25
ABUSE	3,567	4,217	650	18
PENDING YEAR's END <u>3/</u>	3,424	4,022	598	17
FRAUD	1,778	1,979	201	11
ABUSE	1,646	2,043	397	24

1/ The term abuse is used to describe incidents and practices which, although not fraudulent, may directly or indirectly cause financial losses to the Medicare program or its beneficiaries. Where an abuse situation is identified, actions are taken to prevent recurrences and to recover any overpayment.

2/ Calendar year figures are used here to provide as current data as possible.

3/ These figures represent cases in various stages of development, ranging from initial allegations of fraud and abuse not yet investigated to those pending with United States Attorneys.

In calendar year 1972, 90 Medicare fraud cases were referred to U.S. Attorneys for prosecution compared to 89 in 1971. A cumulative total of 232 Medicare fraud cases were referred to the Department of Justice between 1970, when this activity began, through the end of 1972. There were 26 convictions for Medicare fraud during calendar 1972, bringing the cumulative total to 62.

Fifty-two percent of all potential fraud cases in 1972 involved allegations of physician billings for services not rendered (compared with 47 percent in 1971); 17 percent were for provider (hospital, etc.) billings for services not rendered (compared with 16 percent in 1971); and 18 percent involved double billings for a single service (compared with 17 percent in 1971).

Assignment violations continued to dominate abuse workloads, increasing from 57 percent in 1971 to 62 percent during 1971.<sup>4/</sup> Analysis of these violations disclosed that lack of a complete understanding of the assignment is a common causal factor, compounded by high turnover of clerical help in physicians' offices. In an effort to increase understanding of the assignment agreement among physicians and their billing agents, carriers were directed to release explanatory material to their physicians and suppliers. Where these efforts and direct contact with offending physicians have proved ineffective to deal with the problems, the assignment privilege has had to be suspended.

#### Quarterly Program Savings Report

During 1972, we continued to compile a report on Quarterly Program Savings resulting from program integrity activities. This report is designed to measure, on a case-by-case basis, the amount of monies determined to be overpaid and the amount of overpayments actually recovered. Recovery is accomplished through direct repayment or offset against subsequent valid claims.

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<sup>4/</sup> These are cases in which the physician agrees to accept the Medicare reasonable charge as full reimbursement for services rendered and, when the Medicare payment is less than his charges, attempts to collect this difference from the beneficiary.

## Overpayments Recovered During 1972

<u>Quarter Ending</u>	<u>Amount Overpaid</u> <sup>5/</sup>	<u>Amount Recovered</u> <sup>6/</sup>
September 1971	\$ 718,984.90	\$ 714,910.96
December 1971	1,282,152.72	583,835.14
March 1972	995,841.06	794,136.39
June 1972	<u>1,179,650.41</u>	<u>380,623.95</u>
	\$4,176,629.09	\$2,473,506.44

At the end of 1972 there remained a cumulative total of \$6,169,484.21 in overpayments outstanding. This compares to a total outstanding amount of \$5,024,178.65 at the close of 1971.

### Civil Fraud

Another major undertaking in 1972 was the development of procedures for handling the civil fraud aspects of cases referred to the Department of Justice. These procedures result in a case which is as suitable for prosecution under the False Claims Act (31 U.S.C. 231) as it is for the prosecution under the penal provisions of the Social Security Act and the Federal Criminal Code. The documentation used to prove that criminal fraud occurred is also used to prove civil fraud. The penalties for civil fraud are added to any criminal penalties and flow from action instituted usually after the criminal aspects have been disposed of.

The possibility of proceeding under the False Claims Act gives the Government greater leverage in obtaining refunds, since a verdict for the Government under that statute may result in a forfeiture of \$2,000 per false claim<sup>7/</sup> (plus costs), whether or not the claim was paid, plus double damages if it was. Usually, the total potential forfeiture far exceeds the total amount the Government can readily prove was fraudulently obtained, and thus forms the basis for an equitable negotiated settlement based on an estimate

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<sup>5/</sup> This refers only to determination of overpayment made in the indicated period.

<sup>6/</sup> This refers to amounts actually recovered in the indicated period regardless of when the determination of overpayment was made.

<sup>7/</sup> As of March 1973, \$1,554,667 had been collected under the False Claims Act.

of the total overpayment. This method obviates the reinvestigation of every claim, the cost of which would be literally prohibitive.

### Physicians with "High Volume" Service

This study began in September 1969 when Senate Finance Committee staff asked for a listing of solo practicing physicians paid more than \$25,000 under Part B during calendar year 1968. Reports have been provided the Committee staff concerning payments in 1968 and 1969. Although the Senate Finance Committee no longer requires this information, we have found it valuable for administrative purposes and have continued to compile it. The study conducted in 1972 involved payments made in calendar year 1970. Data for the study were obtained, as in the previous two years, from the payment records carriers submit to SSA. From these records were identified some 11,000 billing numbers, all presumably representing solo practitioners to which carriers paid over \$25,000 in 1970. By applying utilization keys to the payment histories of these numbers, we were able to reduce this number to 2900 questionable cases. Further screening eliminated the need for individual investigations in 955 cases, leaving a total of 1945 cases, distributed as indicated below, which required detailed investigation.

Physicians reimbursed over \$100,000	<u>201</u>
Physicians failing SNF utilization Regs	<u>208</u>
Podiatrists reimbursed over \$25,000	<u>15</u>
Repeat physicians found to have abnormal patterns of practice in 1969	<u>148</u>
Other physicians receiving over \$25,000	<u>1,373</u>
TOTAL	1,945

Carriers determined that incorrect payments due to overutilization had occurred in 272 of the cases they reviewed. As of the close of fiscal 1972, exact amounts of the overpayments had been determined in 173 of these cases and in 132 cases, payments to the physicians are suspended pending arrangements for recoupment. The total amount of overpayments determined in the 173 cases is \$1,518,100.

## PART VIII

### PROGRAM EXPERIMENTATION

During 1972, concern about the appropriate cost and use of health care services continued to grow. A number of steps have been undertaken by Medicare over the past several years in an effort to control inappropriate costs and use of services under the program.<sup>1/</sup> We believe those actions have had some beneficial effect in dealing with this problem, which has implications not only for Medicare but for the entire health care system; and in 1972, we continued our efforts to improve the effectiveness of the program's existing utilization review and cost control mechanisms.

The long-term resolution of this problem, however, may well depend on the development of new and more effective mechanisms. To this end, considerable effort was expended during the year in seeking to develop and evaluate alternative methods that could be used under Medicare to achieve more effective cost and utilization control. Our activity focused on the design and conduct of experiments in the three major areas described below: incentive reimbursement, peer review and health maintenance organizations.

#### Incentive Reimbursement Experiments

The Social Security Amendments of 1967 authorized the Secretary to conduct experiments to test the effectiveness of incentives in reducing or retarding increasing program costs while assuring the quality of care. At the close of FY 1972, four incentive reimbursement experiments were in operation and a fifth was scheduled to begin on July 1, 1972.<sup>2/</sup> Monitoring of the ongoing experiments entailed determination of problem areas and the suggestion of possible modifications designed to increase the possibility of success of the experiments. Evaluation of these experiments is being done under contractual arrangements with a number of nongovernmental research organizations. Seven additional experiments were under consideration at the end of the year. In addition, approximately 20 other proposals or ideas for experiments had been received and analyzed.

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<sup>1/</sup> See Fifth Annual Report on Medicare for Fiscal Year 1971, January 3, 1973, pp. 18-21, House Document No. 93-36.

<sup>2/</sup> By June 30, 1973, six experiments were in full operation. The experiment being conducted by the Birmingham Regional Council had become operational and one with the Utah State Division of Health was added.

The four operational experiments are with (1) the Connecticut Hospital Association, (2) Blue Cross of Southern California, (3) the Hospital Insurance Plan (HIP) of Greater New York, and (4) Maryland Blue Cross. The fifth experiment is being conducted by the Birmingham Regional Hospital Council. Each experiment is designed to test a valid theory of cost containment: (1) incentives through peer review in Connecticut; (2) incentives based on productivity standards, combined with industrial engineering assistance in Southern California; (3) the influence of group practice physicians and nurse clinicians in discharge planning in HIP; (4) in-depth industrial and management engineering studies in Maryland; and (5) target projections and group incentives in Birmingham.

#### 1. Connecticut Hospital Association

This plan was developed by the Connecticut Hospital Association with the cooperation of SSA and Connecticut Blue Cross and applies to all patients covered by Medicare and Blue Cross in the 17 3/

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3/ As of June 30, 1973 only 10 hospitals were still participating--the large hospital group had dropped out of the experiment after the end of the second experimental year.

currently participating hospitals. The basic structure of the Connecticut experiment consists of three peer groups of hospitals which are set up on the basis of number of beds and six Budget Approval Boards which review and approve budgets within their peer groups. Target budgets for four departments in each hospital were approved for the 1970 budget year, and for an additional five departments in the second year of the experiment. The departments chosen were those most directly under the control of the hospital administration such as non-maternity nursing, housekeeping, dietary, and pharmacy. In 1971, the original contract was modified to provide for the inclusion of five physician-controlled departments (operating room, post-operative, anesthesiology, radiology, and pathology) in the third year of the experiment. Eight of the original participant-hospitals have been selected to take part in the expanded portion of the experiment, with budget review procedures being used as in the original portion.

Those hospitals whose actual costs are below their target budgets (adjusted for actual volume) receive incentive payments equal to the difference between their actual costs and their adjusted target budgets. In addition, those hospitals whose departmental performance substantially exceeds that of their peer group may receive a reward of up to 2 percent of the year-end costs of that department. Savings will accrue to Medicare and Blue Cross through target budgets that are lower than the costs that would otherwise have been paid.

Unfortunately, most of the larger hospitals have not actively participated. They have cited three technical problems: (1) validity of the industrial engineering standards set for the experiment, (2) validity of the concept of retrospective adjustment of target budgets for volume (and validity of techniques for such adjustments), and (3) applicability of standard productivity statistics as workload measurements.

As of the end of fiscal 1972,<sup>4/</sup> the Connecticut experiment seemed to indicate that:

--Neither of the two principal assumptions of peer review (that hospital personnel would be more knowledgeable about hospital affairs and would tend to be more critical and severe with their peers than laymen) is necessarily true;

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<sup>4/</sup> As of June 30, 1973, the Connecticut experiment was essentially completed. Yale University had undertaken an evaluation of the experiment.

- large hospitals do not seem to respond to cash incentives;
- the budgeting process in hospitals generally needs major improvements; and
- it will be technically difficult to develop a wholly acceptable methodology for retrospectively adjusting target budgets for differences between actual and estimated volume.

## 2. California (Blue Cross of Southern California--CASH)

Under this experiment, hospital efficiency in a sample of 25 Southern California hospitals is measured by comparing actual labor performance with performance standards set by the Commission for Administrative Services in Hospitals (CASH) using industrial engineering techniques. Upon request, CASH provides industrial engineering assistance at no cost to the hospitals to help them improve their efficiency. The incentives provided in the experiment are designed to share with each participating hospital the equivalent cost of labor savings calculated between the previous and current years of operation. Each hospital receives an incentive payment reflecting savings resulting from its own labor cost improvement, based on the rate of such improvement, the level of productivity, and the ratio of the respective third party program's patient days to total patient days.

The problems highlighted by this experiment are similar to those in Connecticut but, in addition, it has been noted many hospital decisions are made more with a view toward the attitudes of the medical staff than considerations of efficiency. Also it has been indicated that competition among hospitals for both patients and medical staff influences the decision-making process. Occupancy in the Southern California area has, in general, been declining during the period of the experiment. The decline in occupancy has an adverse effect on productivity mainly due to the fact that the hospitals have been unwilling to release skilled staff to adjust their staffing patterns in relationship to volume. 5/

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5/ Final reports on the California experiment are due by October 1973. Evaluation of the California experiment is being done by the Hospital Research and Educational Trust and should be completed by May 1974.

### 3. New York

The reimbursement experiment conducted by the Health Insurance Plan (HIP) of Greater New York is designed to determine the degree to which a prepaid group practice plan can develop efficient arrangements for the control of the provision of all medical, home care, and institutional services covered by Medicare. Under this experiment, HIP (which presently receives a capitation payment from Medicare for covered physician services, based on reasonable costs) has extended its operation to attempt to control utilization of hospital and extended care services.

Nine HIP medical groups and six hospitals are fully participating in the project and the groups have been staffed with nurse-clinician coordinators who are actively engaged in discharge planning in the hospitals and who serve as the primary source of ambulatory care for selected patients. Base year figures for 1969 indicate that the per capita reimbursement under Medicare for beneficiaries who are HIP members is higher than for nonmembers in the same area receiving services under fee-for-service arrangements. After the first year of the experiment, figures for 1970 show that the difference between per capita payments for HIP members and other beneficiaries was decreased materially.

HIP has experienced difficulty during the period of the experiment in placing its hospitalized beneficiaries in skilled nursing facilities (SNF's) due to the reluctance on the part of some SNF's in the New York area to accept Medicare patients. This is reflected in the preliminary 1970 data which show sharp reductions in SNF usage both for HIP and the control group. An attempt to improve this situation resulted in an experimental agreement with one SNF for assurance of payment based on certification of HIP physicians. Evaluation of the experiment has been undertaken by Harvard University, and its report is due in December 1973.

### 4. Maryland

This experiment is jointly funded by SSA, Maryland Blue Cross, and the State of Maryland and is being conducted by Hospital Cost Analysis Service (HCAS) in 37 Maryland hospitals under a sub-contract. HCAS reviews the costs of all participating hospitals on a department-by-department basis and those departments which are identified as high cost will be studied in-depth. As a result of the studies, recommendations will be made to the hospitals indicating actions which can be taken to reduce costs. If the hospitals disagree with the recommended actions, they have the right of appeal through a specified process. If the HCAS recommendations are upheld on appeal, and the hospitals still

refuse to follow them, all participating third party payers will be notified to reduce their reimbursement rate as if the recommendation had been implemented. In return for the hospital's agreement to participate in the experiment, they receive, free of charge, management and industrial engineering consultative services. The contract for this experiment was signed September 1, 1971. Evaluation of the experiment is being done by Temple University and should be completed by July 1975.

##### 5. Birmingham

The proposal by the Birmingham Regional Hospital Council was approved as an incentive reimbursement experiment in January 1972 under a two-phase contract. Phase I provides for completion of a mutually acceptable statistical model for projecting BRHC costs. Phase II involves funding of the experiment itself. Phase II will not begin until, and unless, Phase I is successfully completed.<sup>6/</sup>

The BRHC experiment is designed to achieve cost containment by reducing the rate of increase in costs of its member hospitals. To achieve this goal, the experiment provides that costs of the 23 hospitals participating in the experiment will be projected by use of a statistical technique. Incentives will be paid to participating hospitals based upon their cost performance measured against their projected performance. Before any individual hospital can receive an incentive payment, however, the composite performance of all participating hospitals must be below that projected. Evaluation of this experiment is a project of the Georgia Institute of Technology and is due to be completed by December 1976.

#### Prospective Rate Determination

Concern about the inadequacies of retroactive reasonable cost determinations continued to grow during the year. Both the Department and the Congress were aware of the advantages which alternative methods of reimbursement might yield, and during the course of the year, we were exploring approaches which might both support our efforts to curb escalation of health care costs, introduce incentives, and place more effective controls on the cost determination process. Prospective rate determination seemed one of the most promising approaches. Unlike retrospective cost

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<sup>6/</sup> BRHC has submitted the statistical model required for Phase I and been authorized to proceed with implementation of Phase II

reimbursement, it would require that the rate of payment be set in advance of the period to which it would apply. Then if actual costs are less than the prospective rate, the provider would retain all or part of the resultant savings. If actual costs exceed the prospective rate, the provider would bear the loss. It would be expected that a provider would institute cost savings measures to stay within the known reimbursement rate and thus earn its share of any savings. Deficiencies in cost data and limitations in current methodologies for comparing costs among providers, measuring health care output, and estimating costs necessary for efficient delivery of health care are among the problems we can expect to encounter in trying to make prospective reimbursement work.<sup>7/</sup>

#### Peer Review Activities

During 1972, increasing attention was focused on the concept of professional review organizations through which practicing physicians assume responsibility for reviewing utilization of services for which reimbursement is claimed under Medicare and other health insurance programs. The Congress,<sup>8/</sup> organized medicine, and other interested groups were all demonstrating considerable interest in broadening the role of peer review as a means of providing more effective controls on the utilization of medical services. The Department began, therefore, to develop a program of experimental peer review projects designed to: (1) Determine the respective costs and feasibility of implementing the various approaches being advocated; (2) assess their effect on the quality and utilization of medical resources; and (3) identify and resolve systems, data collection and other problems that would result from broad-scale use of Professional Standards Review Organizations such as proposed in legislation then before the Congress. Three experiments were in operation during fiscal year 1972.

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<sup>7/</sup> Section 222 of P.L. 92-603 directs the Secretary of HEW to develop and carry out a number of experiments and demonstration projects to determine the relative advantages of alternative methods of making Medicare payment on a prospective basis to providers rather than on the basis of retroactive cost reimbursement. After enactment of that law, a task force on prospective reimbursement was formed to carry out the administrative and other tasks necessary to carry out this Congressional mandate and report by July 1, 1974. Our goal is to conduct experiments using as many different prospective reimbursement methods as possible, including negotiated rates, formulas, and budget review. We will endeavor to test many of the variations of these different methods and to examine the ways in which individual systems treat variations in volume and wages, capital financing and budget review.

<sup>8/</sup> In late 1970, for example, the Senate approved legislation which would have required review of the professional aspects of services under Medicare and Medicaid to be carried out by Professional Standards Review Organizations (PSRO's). During 1972, similar legislation was introduced in the Senate to H.R. 1, the then pending Social Security Amendments of 1972. PSRO provisions were included in P.L. 92-603 enacted by the Congress in October 1972.

### 1. New York City Health Department

The objectives of this project were to develop one or more prototype procedures for identifying possible hospital inefficiencies, prompt the institution to carry out the studies needed to pinpoint the appropriate remedial action, and assure that the institution takes the action that is indicated. Data that was already available from third parties and other sources was reviewed by the contractor to identify possible aberrant patterns of costs or utilization that would be further reviewed on-site by the contractor. Where improper institutional or professional practices were identified, the hospital would be asked to carry out specific studies in order to fully define the problem and the steps necessary to correct it. Hospitals that did not carry out the recommended studies and make the indicated changes could be subject to various sanctions, including reduced third-party payments. This project was terminated by the government on May 31, 1973, because of administrative problems brought about by its study design.

### 2. Blue Cross of Central Ohio Project

Under this project, which began in July 1971, the Blue Cross Plan has tabulated data on hospital charges and lengths of stay that have been reported on Medicare claims submitted in 1970 and 1971 by the 42 hospitals for which it serves as the intermediary. The data was arrayed to point up hospitals whose patterns of utilization appear to be abnormal.

### 3. San Joaquin, Kern and Fresno Medical Care Foundations

The three Foundations have had subcontracts with California Blue Shield since 1967 to review Medicare claims from physicians in their respective areas. Under a special peer review project which began in 1969, patient profiles and provider (physician) profiles are made available to the Foundations to assist them in reviewing Medicare claims. Each of the Foundations keytapes its own claims data and forwards it to San Joaquin for consolidation. The profiles are then produced by an outside contractor in microfiche and returned to the Foundations. The data generated is being used to establish utilization guidelines and model treatment plans.

One other project which was close to becoming operational as the fiscal year ended,<sup>9/</sup> is now being conducted by the Sacramento Medical Care Foundation and is designed to test the feasibility

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<sup>9/</sup> This 12-month project became operational on October 1, 1972.

of applying the Foundation's Certified Hospital Admission Program (CHAP) approach to Medicare hospital and SNF admissions, and home health starts of care in a five-county area in California.

Under CHAP, a physician submits an application requesting certification for hospital admission along with certain information concerning the patient's condition. A CHAP nurse or physician authorizes an appropriate length of stay. A Foundation nurse coordinator at each hospital verifies the diagnosis after admission, follows up on the patient's progress, and identifies any changes which might warrant a revision in the authorized length of stay. Any extension beyond the initially approved period are requested by the patient's physician and authorized by a Foundation physician.

The Foundation's certification form is attached to the billing form submitted by the hospital (or other provider) to the Medicare intermediary. Claims bearing the CHAP certification are routinely paid by the intermediary provided they are satisfied, on the basis of a sample review of claims, that the action taken by the Foundation on requests for certification provides an adequate basis for presuming that services certified by CHAP meet the applicable level-of-care requirements.

Extensive discussions were also held during fiscal 1972 with the New Mexico and Colorado Foundations for Medical Care and contracts were signed by both organizations for projects they suggested.<sup>10/</sup> These and other peer review projects are expected to provide invaluable operational experience for the PSRO planning effort and for evaluating the impact of professional review activities on health care use, quality, and costs.<sup>11/</sup>

#### Health Maintenance Organization (HMO) Experimentation

Operating under the authority of section 402 of the 1967 amendments to the Social Security Act <sup>12/</sup>to develop and engage in experiments which may "have the effect of increasing the efficiency and economy

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<sup>10/</sup> The New Mexico contract was signed on June 27, 1973, and Colorado Foundation signed its contract on June 13, 1973.

<sup>11/</sup> The PSRO provisions of P.L. 92-603 become effective on January 1, 1974.

<sup>12/</sup> 42 U.S.C. 1395b-1

of health services," we undertook an experimental program to test methods for reimbursing health maintenance organizations.<sup>13/</sup> Numerous proposals were submitted during fiscal 1972 and were in varying stages of development. Through such experimentation, we expected to obtain information as to the advantages and disadvantages of HMO arrangements to both providers and consumers of health care services.

We were especially interested in experiments which would test factors affecting program costs. Such factors include the capitation formula upon which to base payments, methods of controlling unnecessary services to beneficiaries, effects of population mix, and the degree of integration of the different levels of care under one administration. In addition, there was interest in such areas as methods and problems of marketing an HMO to a Medicare population, utilization review, and maintenance of quality of services both within the contracting HMO and in outside facilities from which provider services are purchased.

Four sets of criteria were applied in deciding where reimbursement techniques would be tested:

- (1) an organization's interest in becoming an HMO;
- (2) capacity to undertake proposal development immediately;
- (3) differing structural characteristics such as closed panel group practice prepayment plans, medical care foundations, neighborhood health centers and affiliation with teaching hospitals; and
- (4) location--e.g. urban or rural.

It was anticipated that during 1973 at least four experimental contracts would be approved.<sup>14/</sup>

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<sup>13/</sup> An HMO is a public or private organization which provides or arranges for comprehensive health services to enrolled individuals under a prepaid group health or other capitation plan.

<sup>14/</sup> Enactment of P.L. 92-603 moved the focus of HMO activities from experimentation to preparation for operation of the HMO program created by the new law. Although the range of issues needing to be addressed through the experimental approach has been greatly diminished, development of one rather significant experiment has been continued. This experiment is intended to test the effect of instituting a savings sharing arrangement which is not subject to the law's limitation of 80 percent of the average adjusted per capita rate for the service area. Under the experiment, the capitation rate will be fixed in advance on the basis of a projection of the average adopted per capita rate for the service area. The experiment will also test the effect of instituting an enriched benefit structure derived from projected savings which would be used to attract enrollees on a limited open enrollment basis.

APPENDIX A

SUMMARY DATA ON MEDICARE OPERATIONS

## SUMMARY DATA ON MEDICARE OPERATIONS

### Beneficiaries

The number of persons entitled to hospital insurance increased to 21.0 million on January 1, 1972, a gain of 378,000 or 1.8 percent since January 1, 1971. The number of hospital insurance enrollees includes nearly every American age 65 and over. <sup>1/</sup>

On January 1, 1972, the number of persons enrolled for supplementary medical insurance reached 20.1 million, representing a 407,000 or 2.1 percent increase since January 1, 1971. About 96 percent of the hospital insurance enrollees were also enrolled for medical insurance.

### Health Care Resources

At the close of fiscal 1972, there was a net decrease of 19 participating hospitals from the total at the end of fiscal 1971, bringing the number of hospitals participating in the Medicare program on June 30, 1972, to 6,726. Among participating hospitals there were 6,131 short-stay, down 22 from last year. The total number of beds in participating hospitals was 1,156,000, a decrease of 32,000.

By the end of fiscal 1972, there were 4,041 participating skilled nursing facilities (SNF's) with 291,600 beds--a decrease of 246 SNF's and 16,000 beds since a year earlier.

A total of 2,222 home health agencies were certified to participate in Medicare on June 30, 1972, a decrease of 62 agencies during the 12-month period. About three-fifths of the agencies provide visiting nurse care and two or more additional services, while two-fifths offer the basic requirement of visiting nurse care and one additional service.

Since July 1, 1968, outpatient physical therapy services have been covered when furnished by, or under the supervision of, qualified

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<sup>1/</sup> Excluded from coverage are certain Federal employees covered under the Federal Employees Health Benefits Act, aliens admitted for permanent residence but not residing in the United States for 5 consecutive years preceding their application for hospital insurance entitlement, and persons convicted of crimes against the United States. Included in the total are beneficiaries residing in foreign countries and persons living in Puerto Rico and United States territories and possessions.

"providers of service." In addition physical therapy has been covered since the start of the program when furnished on an inpatient basis or in physicians' offices or as part of covered home health services. At the end of fiscal year 1972, a total of 109 clinics, rehabilitation agencies and public health agencies--compared to 113 a year earlier--had been certified to participate as outpatient physical therapy providers, in addition to participating hospitals, skilled nursing facilities and home health agencies.

The 1972 Amendments extended coverage of physical therapy services under medical insurance to include the home and office services of the physical therapists in independent practice. Such physical therapists must meet licensing and other standards prescribed by the Secretary in regulations. In addition, a hospital or skilled nursing facility may provide covered outpatient physical therapy services under Part B to its inpatients who have exhausted their inpatient benefits under Part A.

The following table summarizes the changes which have occurred in participating facilities between 1971 and 1972.

Type of facility	Facilities		
	July 1971	July 1972	Percent change
Hospitals 2/.....	6,745	6,726	-0.3
Short-stay.....	6,153	6,131	-0.4
Psychiatric.....	335	346	+3.3
Tuberculosis.....	95	80	-15.8
Other long stay.....	162	169	+4.3
Skilled Nursing facilities 2/	4,287	4,041	-5.7
Home health agencies.....	2,284	2,222	-2.7
Independent laboratories...	2,751	2,873	+4.4

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2/ Excludes 17 Christian Science sanatoriums.

Type of facility	Beds		
	July 1971	July 1972	Percent change
Hospitals <u>2/</u> .....	1,188,013	1,155,982	-2.7
Short stay.....	834,514	850,070	+1.9
Psychiatric.....	300,696	259,329	-13.8
Tuberculosis.....	18,995	15,065	-20.7
Other long stay.....	33,808	31,518	-6.8
Skilled Nursing facilities <u>2/</u>	307,548	291,636	-5.2
Home health agencies.....	---	---	---
Independent laboratories...	---	---	---

### Benefit Payments

In fiscal 1972, Medicare's sixth year, the program paid \$6.1 billion in benefits under the hospital insurance program compared to \$5.4 billion during fiscal 1971. Medical insurance benefit payments amounted to \$2.3 billion, up from \$2.0 billion paid in fiscal 1971.

An analysis of hospital insurance claims approved for payment in fiscal 1972 and recorded in SSA records shows that inpatient hospital services accounted for 88.2 percent of paid claims, but 96.5 percent of total disbursements. The respective percentage figures for other services were: extended care services, 5.2 percent of claims and 2.7 percent of disbursements; posthospital home health services, 6.6 percent of claims and 0.8 percent of disbursements.

A breakdown of medical insurance bills approved for payment in fiscal 1972 and recorded in SSA records indicates that physicians' services accounted for 81.5 percent of paid bills, and 88.8 percent of total disbursements. For other services, the respective

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2/ Excludes 17 Christian Science sanatoriums.

percentage figures were: outpatient hospital services 10.9 percent of bills and 5.9 percent of disbursements; other medical services and supplies, 4.6 percent of bills and 3.8 percent of disbursements; home health care, 0.6 percent of bills and 0.7 percent of disbursements; and independent laboratory services, 2.3 percent of bills and 0.7 percent of disbursements. In fiscal 1972, excluding claims from hospital-based physicians, 56.4 percent of the claims submitted for physicians services were assigned. The total assignment percentage, including hospital-based physicians, was 60.6 percent.

Charges were reduced on 41.9 percent of approved claims processed by carriers in fiscal 1971 and on 46.6 percent of approved claims processed in fiscal 1972. The average dollar amount of reduction per reduced claim was \$15.30 in fiscal 1972 and \$15.51 in fiscal 1971. Total reductions on approved claims were \$300 million in fiscal 1971 and \$362 million in fiscal 1972.

### Inpatient Hospital Services

During fiscal 1972, there were 6.5 million covered hospital admissions, up about 250,000 over fiscal 1971. The fiscal 1972 total represented an annual average of 313 admissions to short and long-term hospitals for every 1,000 persons covered under the program, a 2.6 percent increase over the previous year's rate of 305.

During fiscal 1972, a total of 3,365 claims for emergency hospital services were processed--a decrease of 1,100 claims from the preceding year. About 50 percent were allowed, compared to 44 percent last year, while the remainder were either wholly or partially denied.

Hospitals were paid an estimated \$5.9 billion for inpatient services during fiscal 1972, an increase of about \$700 million over the preceding 12 months. Reimbursement averaged \$824 per recorded inpatient hospital bill; the comparable figure for the previous year was \$762.

### Extended Care Services

During fiscal 1972, there were 396,900 admissions to skilled nursing facilities down from 421,300 the previous year and an annual rate of 19.1 per 1,000 persons covered, compared to 20.4 per 1,000 in fiscal 1971. There was about one SNF admission for covered posthospital care, on the average, for every 16 hospital admissions.

An estimated \$180 million was paid to SNF's during fiscal 1972. Reimbursement averaged \$392 per recorded bill compared to \$375 in fiscal 1971.

### Home Health Services

During fiscal year 1972 an estimated \$69 million was paid for home health services. This represented about a 32 percent decrease from the previous year. The average payment per recorded bill was \$89 under hospital insurance and \$54 under medical insurance, compared to \$84 and \$53 respectively in the preceding 12-month period.

### Outpatient Hospital Services

In fiscal 1972, 5.5 million outpatient hospital bills--both diagnostic and therapeutic--were reimbursed under Medicare, up from over 4.6 million during the previous 12 months. Total payments to hospitals for covered outpatient services were estimated at \$179 million, up from \$120 million in fiscal 1971.

### Physicians' Services

In fiscal 1972, a total of 39.3 million bills for physicians' services were approved for payment and recorded in Social Security Administration records, in comparison to 36.4 million bills in fiscal 1971. Of these bills, 15 percent were for surgical services and 85 percent for medical services. Reasonable charges for surgical bills amounted to \$990 million compared to \$891 the previous year; for medical bills these charges amounted to \$1.5 billion compared to \$1.4 billion in the previous year.

For physicians' surgical services, the proportion of reasonable charges reimbursed by Medicare was 75.9 percent; for medical services, 71.9 percent.

### Other Medical Services and Supplies

There were 3.4 million paid bills recorded for nonphysician medical services, other than home health and outpatient hospital services in fiscal 1972--up from 2.6 million in the preceding year.

Reasonable charges for independent laboratory services total \$20 million compared to \$15 million a year earlier, while the figure for "other medical services" was \$108 million compared to \$86 million a year earlier. Included in the "other" category are rental or purchase of durable medical equipment, ambulance services, prosthetic devices, and certain other medical services and supplies.

APPENDIX B

SELECTED DATA FROM MEDICARE PROGRAM FOR FISCAL YEAR 1972

Selected Data from the Medicare Program for Fiscal Year 1972

	All areas	Alabama	Alaska
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	20,966,267	338,827	7,074
Supplementary medical insurance (SMI).....	20,145,286	331,789	5,690
Benefits paid (in thousands):			
Hospital insurance.....	\$6,109,139	\$74,254	\$1,193
Supplementary medical insurance.....	2,255,069	30,353	523
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	6,726	128	22
General hospitals.....	6,300	126	21
Number of beds.....	881,588	14,641	752
Number beds per 1,000 HI enrollees.....	42.0	43.2	106.3
Psychiatric hospitals. ....	346	1	1
Tuberculosis hospitals.....	80	1	0
Skilled nursing facilities.....	4,041	96	4
Number of beds <u>3/</u> .....	291,636	5,366	147
Number beds per 1,000 HI enrollees.....	13.9	15.8	20.8
Home health agencies.....	2,222	67	1
Independent laboratories.....	2,873	13	2
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	6,495,200	115,100	1,900
Skilled nursing facility.....	396,900	6,300	<u>5/</u>
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	313	340	266
Skilled nursing facility.....	19.1	18.6	10.5

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

5/ Less than 50 admissions.

Selected Data from the Medicare Program for Fiscal Year 1972

	Arizona	Arkansas	California
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	171,284	245,934	1,841,313
Supplementary medical insurance (SMI).....	165,061	239,261	1,804,543
Benefits paid (in thousands):			
Hospital insurance.....	\$58,261	\$50,375	\$654,814
Supplementary medical insurance.....	21,245	19,449	306,321
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	61	99	591
General hospitals.....	57	96	552
Number of beds.....	7,177	8,331	79,356
Number beds per 1,000 HI enrollees.....	41.9	33.9	43.1
Psychiatric hospitals. ....	3	2	37
Tuberculosis hospitals.....	1	1	2
Skilled nursing facilities.....	16	16	920
Number of beds <u>3/</u> .....	1,181	1,028	78,337
Number beds per 1,000 HI enrollees.....	6.9	4.2	42.5
Home health agencies.....	9	76	83
Independent laboratories.....	43	11	718
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	57,100	98,000	547,700
Skilled nursing facility.....	2,900	900	92,200
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	333	399	297
Skilled nursing facility.....	16.8	3.6	50.1

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Colorado	Connecticut	Delaware
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	194,668	296,130	46,664
Supplementary medical insurance (SMI).....	190,366	290,814	45,208
Benefits paid (in thousands):			
Hospital insurance.....	\$69,052	\$98,557	\$11,373
Supplementary medical insurance.....	24,143	28,990	3,992
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	87	51	10
General hospitals.....	83	43	8
Number of beds.....	9,996	10,885	1,839
Number beds per 1,000 HI enrollees.....	51.3	36.8	39.4
Psychiatric hospitals.....	4	8	1
Tuberculosis hospitals.....	0	0	1
Skilled nursing facilities.....	62	115	13
Number of beds <u>3/</u> .....	3,874	10,419	616
Number beds per 1,000 HI enrollees.....	19.9	35.2	13.2
Home health agencies.....	20	89	7
Independent laboratories.....	43	50	8
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	75,700	77,900	11,800
Skilled nursing facility.....	4,200	10,400	700
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	389	263	253
Skilled nursing facility.....	21.5	35.1	15.7

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographical distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	District of		
	Columbia	Florida	Georgia
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Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	65,724	999,189	379,811
Supplementary medical insurance (SMI).....	62,336	976,807	369,649
Benefits paid (in thousands):			
Hospital insurance.....	\$31,939	\$269,422	\$81,741
Supplementary medical insurance .....	14,780	149,259	34,520
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	17	192	166
General hospitals.....	14	180	159
Number of beds.....	5,561	31,894	18,320
Number beds per 1,000 HI enrollees.....	84.6	31.9	48.2
Psychiatric hospitals. ....	3	10	6
Tuberculosis hospitals.....	0	2	1
Skilled nursing facilities.....	5	151	66
Number of beds <u>3/</u> .....	884	8,877	4,292
Number beds per 1,000 HI enrollees.....	13.5	8.9	11.3
Home health agencies.....	3	40	14
Independent laboratories.....	5	125	24
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	22,000	324,000	127,200
Skilled nursing facility.....	600	21,100	4,600
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	334	324	335
Skilled nursing facility.....	8.6	21.1	12.0
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1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Hawaii	Idaho	Illinois
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	47,904	72,196	1,110,171
Supplementary medical insurance (SMI).....	47,052	70,018	1,078,646
Benefits paid (in thousands):			
Hospital insurance.....	\$12,775	\$15,138	\$369,778
Supplementary medical insurance.....	6,972	5,815	104,505
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	25	46	288
General hospitals.....	24	46	263
Number of beds.....	2,712	2,474	49,903
Number beds per 1,000 HI enrollees.....	56.6	34.3	45.0
Psychiatric hospitals.....	1	0	17
Tuberculosis hospitals.....	0	0	8
Skilled nursing facilities.....	13	31	151
Number of beds <u>3/</u> .....	1,312	1,341	7,948
Number beds per 1,000 HI enrollees.....	27.4	18.6	7.2
Home health agencies.....	5	9	81
Independent laboratories.....	15	2	166
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	13,800	23,000	345,600
Skilled nursing facility.....	1,300	1,600	13,600
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	287	319	311
Skilled nursing facility.....	27.4	21.6	12.2

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Indiana	Iowa	Kansas
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	505,070	357,525	272,968
Supplementary medical insurance (SMI).....	487,795	349,480	265,414
Benefits paid (in thousands):			
Hospital insurance.....	\$129,288	\$91,706	\$67,874
Supplementary medical insurance.....	37,049	25,678	22,461
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	135	150	162
General hospitals.....	124	144	156
Number of beds.....	21,193	14,702	12,404
Number beds per 1,000 HI enrollees.....	42.0	41.1	45.4
Psychiatric hospitals. ....	8	5	5
Tuberculosis hospitals.....	3	1	1
Skilled nursing facilities.....	92	51	38
Number of beds <u>3/</u> .....	3,899	1,831	1,122
Number beds per 1,000 HI enrollees.....	7.7	5.1	4.1
Home health agencies.....	30	46	36
Independent laboratories.....	37	14	24
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	148,200	127,100	101,900
Skilled nursing facility.....	7,900	4,300	2,800
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	293	356	373
Skilled nursing facility.....	15.6	12.0	10.3

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Kentucky	Louisiana	Maine
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	347,044	314,475	123,148
Supplementary medical insurance (SMI).....	340,238	289,173	121,000
Benefits paid (in thousands):			
Hospital insurance.....	\$74,082	\$77,739	\$30,193
Supplementary medical insurance.....	25,631	25,177	9,551
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	126	136	55
General hospitals.....	115	130	55
Number of beds.....	12,310	15,273	4,609
Number beds per 1,000 HI enrollees.....	35.5	48.6	37.4
Psychiatric hospitals. ....	5	5	0
Tuberculosis hospitals.....	6	1	0
Skilled nursing facilities.....	82	15	20
Number of beds <u>3/</u> .....	5,167	1,417	749
Number beds per 1,000 HI enrollees.....	14.9	4.5	6.1
Home health agencies.....	32	78	23
Independent laboratories.....	33	29	0
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	117,500	114,100	37,900
Skilled nursing facility.....	8,000	2,000	1,800
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	339	363	308
Skilled nursing facility.....	23.1	6.4	14.5

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Maryland	Massachusetts	Michigan
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	303,293	640,048	784,439
Supplementary medical insurance (SMI).....	292,373	626,338	764,913
Benefits paid (in thousands):			
Hospital insurance.....	\$90,626	\$278,689	\$269,780
Supplementary medical insurance.....	29,211	70,031	80,365
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	61	185	251
General hospitals.....	51	164	237
Number of beds.....	12,138	29,415	36,044
Number beds per 1,000 HI enrollees.....	40.0	46.0	45.9
Psychiatric hospitals. ....	8	18	13
Tuberculosis hospitals.....	2	3	1
Skilled nursing facilities.....	56	94	151
Number of beds <u>3/</u> .....	4,595	6,761	13,257
Number beds per 1,000 HI enrollees.....	15.2	10.6	16.9
Home health agencies.....	24	166	47
Independent laboratories.....	63	104	94
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	70,800	194,800	233,200
Skilled nursing facility.....	4,900	12,800	13,500
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	233	304	297
Skilled nursing facility.....	16.2	20.1	17.2

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Montana	Nebraska	Nevada
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	71,350	186,802	34,585
Supplementary medical insurance (SMI).....	69,402	181,748	33,273
Benefits paid (in thousands):			
Hospital insurance.....	\$18,614	\$45,328	\$12,995
Supplementary medical insurance.....	6,031	16,893	3,462
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	64	115	22
General hospitals.....	63	111	20
Number of beds.....	3,646	8,393	2,043
Number beds per 1,000 HI enrollees.....	51.1	44.9	59.1
Psychiatric hospitals. ....	1	4	2
Tuberculosis hospitals.....	0	0	0
Skilled nursing facilities.....	22	21	14
Number of beds <u>3/</u> .....	731	976	429
Number beds per 1,000 HI enrollees.....	10.2	5.2	12.4
Home health agencies.....	10	6	3
Independent laboratories.....	5	9	14
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	30,800	70,800	11,900
Skilled nursing facility.....	900	1,700	1,200
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	431	379	343
Skilled nursing facility.....	12.2	9.1	34.1

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Minnesota	Mississippi	Missouri
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	421,246	231,694	569,461
Supplementary medical insurance (SMI).....	413,390	223,789	554,014
Benefits paid (in thousands):			
Hospital insurance.....	\$138,868	\$51,222	\$165,425
Supplementary medical insurance.....	41,997	26,618	50,902
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	195	108	172
General hospitals.....	186	107	163
Number of beds.....	20,059	8,875	25,001
Number beds per 1,000 HI enrollees.....	47.6	38.3	43.9
Psychiatric hospitals. ....	7	0	9
Tuberculosis hospitals.....	2	1	0
Skilled nursing facilities.....	89	22	60
Number of beds <u>3/</u> .....	3,998	858	3,481
Number beds per 1,000 HI enrollees.....	9.5	3.7	6.1
Home health agencies.....	60	86	28
Independent laboratories.....	12	12	56
Number of admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	160,100	91,900	201,600
Skilled nursing facility.....	7,600	1,700	5,300
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	380	397	354
Skilled nursing facility.....	18.1	7.5	9.2

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	New Hampshire	New Jersey	New Mexico
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	84,873	711,571	77,565
Supplementary medical insurance (SMI).....	81,918	695,526	73,814
Benefits paid (in thousands):			
Hospital insurance.....	\$19,967	\$183,237	\$17,953
Supplementary medical insurance.....	6,853	86,156	6,409
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	34	123	48
General hospitals.....	32	112	46
Number of beds.....	2,952	27,520	3,879
Number beds per 1,000 HI enrollees.....	34.8	38.7	50.0
Psychiatric hospitals.....	2	10	2
Tuberculosis hospitals.....	0	1	0
Skilled nursing facilities.....	14	114	12
Number of beds <u>3/</u> .....	738	8,007	648
Number beds per 1,000 HI enrollees.....	8.7	11.3	8.4
Home health agencies.....	39	48	5
Independent laboratories.....	2	132	24
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	26,600	171,500	24,900
Skilled nursing facility.....	2,000	15,200	900
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	313	241	322
Skilled nursing facility.....	23.1	21.3	11.6

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	New York	North Carolina	North Dakota
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Number of beneficiaries as of January 1, 1972 <u>1</u> /:			
Hospital insurance (HI).....	1,981,767	435,456	69,680
Supplementary medical insurance (SMI).....	1,915,073	422,395	67,887
Benefits paid (in thousands):			
Hospital insurance.....	\$720,144	\$99,231	\$20,311
Supplementary medical insurance.....	296,636	30,483	5,872
Number participating facilities as of July 1, 1972:			
All hospitals <u>2</u> /.....	395	151	58
General hospitals.....	355	142	57
Number of beds.....	80,688	19,517	3,489
Number beds per 1,000 HI enrollees.....	40.7	44.8	50.1
Psychiatric hospitals.....	36	5	1
Tuberculosis hospitals.....	4	4	0
Skilled nursing facilities.....	306	50	5
Number of beds <u>3</u> /.....	38,343	4,236	151
Number beds per 1,000 HI enrollees.....	19.3	9.7	2.2
Home health agencies.....	127	33	9
Independent laboratories.....	237	13	9
Number of Admissions during the fiscal year <u>4</u> /:			
All inpatient hospital.....	499,200	138,200	31,800
Skilled nursing facility.....	34,800	6,300	400
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	252	317	456
Skilled nursing facility.....	17.6	14.5	6.1

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Ohio	Oklahoma	Oregon
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	1,014,633	305,176	235,568
Supplementary medical insurance (SMI).....	982,007	298,751	225,620
Benefits paid (in thousands):			
Hospital insurance.....	\$299,691	\$75,299	\$58,724
Supplementary medical insurance.....	80,409	30,219	24,770
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	239	135	89
General hospitals.....	218	129	85
Number of beds.....	45,821	11,594	7,667
Number beds per 1,000 HI enrollees.....	45.2	38.0	32.5
Psychiatric hospitals.....	12	5	3
Tuberculosis hospitals.....	9	1	1
Skilled nursing facilities.....	184	13	59
Number of beds <u>3/</u> .....	14,419	691	2,999
Number beds per 1,000 HI enrollees.....	14.2	2.3	12.7
Home health agencies.....	96	56	24
Independent laboratories.....	102	46	36
Number of admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	293,200	116,700	71,600
Skilled nursing facility.....	22,800	2,000	6,700
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	289	383	304
Skilled nursing facility.....	22.4	6.5	28.4

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Pennsylvania	Rhode Island	South Carolina
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	1,298,811	106,679	202,550
Supplementary medical insurance (SMI).....	1,254,589	103,965	193,337
Benefits paid (in thousands):			
Hospital insurance.....	\$366,346	\$35,817	\$37,655
Supplementary medical insurance.....	133,339	13,403	12,683
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	290	18	75
General hospitals.....	257	16	70
Number of beds.....	50,662	4,545	8,978
Number beds per 1,000 HI enrollees.....	39.0	42.6	44.3
Psychiatric hospitals. ....	30	2	4
Tuberculosis hospitals.....	3	0	1
Skilled nursing facilities.....	227	23	63
Number of beds <u>3/</u> .....	17,669	1,262	4,313
Number beds per 1,000 HI enrollees.....	13.6	11.8	21.3
Home health agencies.....	118	13	37
Independent laboratories.....	135	19	11
Number of Admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	360,000	28,400	59,800
Skilled nursing facility.....	22,200	3,300	4,200
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	277	267	295
Skilled nursing facility.....	17.3	31.1	20.5

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	South Dakota	Tennessee	Texas
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	82,733	399,601	1,026,809
Supplementary medical insurance (SMI).....	80,240	389,397	1,008,484
Benefits paid (in thousands):			
Hospital insurance.....	\$19,827	\$101,198	\$290,138
Supplementary medical insurance.....	5,445	32,511	120,025
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	62	146	493
General hospitals.....	62	138	477
Number of beds.....	3,560	18,097	48,993
Number beds per 1,000 HI enrollees.....	43.0	45.3	47.7
Psychiatric hospitals.....	0	4	13
Tuberculosis hospitals.....	0	4	3
Skilled nursing facilities.....	10	57	79
Number of beds <u>3/</u> .....	502	2,548	4,139
Number beds per 1,000 HI enrollees.....	6.1	6.4	4.0
Home health agencies.....	22	84	46
Independent laboratories.....	4	23	150
Number of admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	33,500	146,700	406,500
Skilled nursing facility.....	700	6,600	5,500
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	405	367	396
Skilled nursing facility.....	7.9	16.5	5.3

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Utah	Vermont	Virginia
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Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	81,032	50,730	378,494
Supplementary medical insurance (SMI).....	77,613	49,668	362,923
Benefits paid (in thousands):			
Hospital insurance.....	\$16,457	\$15,219	\$87,306
Supplementary medical insurance.....	7,412	4,571	33,267
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	39	20	117
General hospitals.....	38	18	105
Number of beds.....	3,540	1,964	18,003
Number beds per 1,000 HI enrollees.....	43.7	38.7	47.6
Psychiatric hospitals.....	1	2	9
Tuberculosis hospitals.....	0	0	3
Skilled nursing facilities.....	19	16	56
Number of beds <u>3/</u> .....	735	833	2,817
Number beds per 1,000 HI enrollees.....	9.1	16.4	7.4
Home health agencies.....	11	17	137
Independent laboratories.....	16	5	22
Number of admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	23,500	17,300	116,200
Skilled nursing facility.....	1,200	1,600	4,300
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	290	340	307
Skilled nursing facility.....	14.5	30.8	11.5

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Washington	West Virginia	Wisconsin
Number of beneficiaries as of January 1, 1972 <u>1/</u> :			
Hospital insurance (HI).....	333,472	202,777	487,725
Supplementary medical insurance (SMI).....	324,884	197,208	477,872
Benefits paid (in thousands):			
Hospital insurance.....	\$85,306	\$44,997	\$146,395
Supplementary medical insurance.....	34,182	17,074	40,403
Number participating facilities as of July 1, 1972:			
All hospitals <u>2/</u> .....	120	80	175
General hospitals.....	114	76	161
Number of beds.....	11,443	9,068	21,032
Number beds per 1,000 HI enrollees.....	34.3	44.7	43.1
Psychiatric hospitals.....	5	4	9
Tuberculosis hospitals.....	1	0	5
Skilled nursing facilities.....	99	20	121
Number of beds <u>3/</u> .....	3,626	1,167	6,432
Number beds per 1,000 HI enrollees.....	10.9	5.8	13.2
Home health agencies.....	21	19	66
Independent laboratories.....	62	10	20
Number of admissions during the fiscal year <u>4/</u> :			
All inpatient hospital.....	106,800	74,200	157,800
Skilled nursing facility.....	10,300	1,800	7,100
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital.....	320	366	324
Skilled nursing facility.....	30.8	8.9	14.5

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

# Selected Data from the Medicare Program for Fiscal Year 1972

	Wyoming	Puerto Rico
Number of beneficiaries as of January 1, 1972 <u>1/</u> :		
Hospital insurance (HI).....	31,876	185,935
Supplementary medical insurance (SMI).....	30,731	98,307
Benefits paid (in thousands):		
Hospital insurance.....	\$6,696	\$19,347
Supplementary medical insurance.....	2,170	8,805
Number participating facilities as of July 1, 1972:		
All hospitals <u>2/</u> .....	29	65
General hospitals.....	28	61
Number of beds.....	1,528	6,488
Number beds per 1,000 HI enrollees.....	47.9	34.9
Psychiatric hospitals.....	1	2
Tuberculosis hospitals.....	0	2
Skilled nursing facilities.....	1	6
Number of beds <u>3/</u> .....	21	414
Number beds per 1,000 HI enrollees.....	0.6	2.2
Home health agencies.....	10	3
Independent laboratories.....	3	61
Number of admissions during the fiscal year <u>4/</u> :		
All inpatient hospital.....	12,000	25,000
Skilled nursing facility.....	200	400
Number of admissions per 1,000 HI enrollees:		
All inpatient hospital.....	375	134
Skilled nursing facility.....	4.9	2.0

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1972

	Guam, Virgin Islands and Other Outlying Areas
Number of beneficiaries as of January 1, 1972 <u>1/</u> :	
Hospital insurance (HI).....	5,160
Supplementary medical insurance (SMI).....	4,140
Benefits paid (in thousands):	
Hospital insurance.....	\$777
Supplementary medical insurance.....	48
Number participating facilities as of July 1, 1972:	
All hospitals <u>2/</u> .....	5
General hospitals.....	5
Number of beds.....	614
Number beds per 1,000 HI enrollees.....	11.9
Psychiatric hospitals.....	0
Tuberculosis hospitals.....	0
Skilled nursing facilities.....	1
Number of beds <u>3/</u> .....	33
Number beds per 1,000 HI enrollees.....	6.4
Home health agencies.....	2
Independent laboratories.....	0
Number of admissions during the fiscal year <u>4/</u> :	
All inpatient hospital.....	700
Skilled nursing facility.....	<100
Number of admissions per 1,000 HI enrollees:	
All inpatient hospital.....	136
Skilled nursing facility.....	1.0

1/ Based on data recorded as of October 12, 1972.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through January 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1972 are received and processed by the Social Security Administration.

APPENDIX C

SOCIAL SECURITY AMENDMENTS OF 1972 (Public Law 92-603):  
SUMMARY OF MEDICARE PROVISIONS

SUMMARY OF MEDICARE PROVISIONS

Medicare for the disabled.--Medicare protection is extended to persons entitled for not less than 24 consecutive months to cash benefits under the social security and railroad retirement programs because they are disabled. Coverage includes disabled workers at any age, disabled widows, and disabled dependent widowers between ages 50 and 65; women aged 50 or older who are entitled to mother's benefits and, for 24 months before the first month they would have been entitled to Medicare protection, met all the requirements for disability benefits except for actual filing of a disability claim; adult disabled children (of deceased, disabled, or retired workers) aged 18 and over who receive social security benefits because they became disabled before reaching age 22; and disabled qualified railroad retirement annuitants.

Medicare protection under this provision will begin with the later of (a) July 1973 or (b) the 25th consecutive month of an individual's entitlement to social security disability benefits and will terminate the month following the month notice of termination of disability benefits is mailed. (Section 201)

Chronic kidney disease deemed to constitute a disability for purposes of Medicare.--Effective July 1, 1973, Medicare coverage is extended to individuals under age 65 who are currently or fully insured or entitled to monthly social security benefits, and to the spouses or dependent children of such individuals, who require hemodialysis or renal transplantation for chronic renal disease. Such individuals are deemed to be disabled for purposes of coverage under both parts of Medicare. Eligibility for coverage begins with the third month after the month in which a course of renal hemodialysis begins, unless the claimant received a kidney transplantation in or before such third month. In the latter event, coverage may begin with the month of transplantation or with prior month, if in such prior month and continuing until the transplant occurs, he is hospitalized in preparation for and anticipation of such transplant surgery. Coverage extends through the twelfth month after the month in which an individual had a transplant or dialysis terminates. Benefits include those of both parts of Medicare, with the usual deductibles and coinsurance. The Secretary is authorized to limit reimbursement for treatment to kidney disease treatment centers that meet regulatory requirements. These requirements include a minimal utilization rate for covered procedures and a medical review board to screen patients for medical suitability for treatment. (Section 299K)

Health Maintenance Organization option.--Individuals eligible for both parts of Medicare, or for SMI only, may choose to have their covered health care provided through a health maintenance organization (HMO)--a prepaid group health or other capitation plan that meets prescribed standards. Two methods of reimbursement for HMO's are to be established. Under the first, an HMO will be "at risk" and payments will be made on an incentive capitation basis. This method, which can be used only by substantial, established HMO's, will permit the HMO and the Government to share, according to a prescribed formula, in any savings the HMO achieves in relation to adjusted average per capita costs of covered health services for persons outside the HMO. The second method, which must be used by newly established HMO's and may be used by any other HMO, provides for interim monthly capitation payments subject to year-end adjustment that reflects the HMO's actual reasonable costs of providing Medicare-covered services.

A beneficiary enrolled with an established HMO that uses the risk-sharing method of reimbursement will receive covered services only through the HMO, except for emergency services and urgently needed services received when he is temporarily outside the HMO's service area. A beneficiary enrolled in an HMO receiving cost reimbursement will not be required to use the HMO as his single source of health care. Payment will be made by Medicare in the usual manner for services he receives outside the HMO.

The provision is effective with respect to services provided on or before July 1, 1973. (Section 226)

Professional Standards Review Organizations.--By January 1, 1974, the Secretary must establish areas throughout the United States with respect to which Professional Standards Review Organizations (PSRO's) may be designated. They are to consist of substantial numbers of practicing physicians (usually 300 or more) in a local area and will be responsible for comprehensive and ongoing review of services covered under the Medicare, Medicaid, and maternal and child health care programs. They are to assure that services are (1) medically necessary and (2) provided in accordance with professional standards. The PSRO's are not required to review services other than institutional care and services unless they so choose and the Secretary agrees. They will not be involved with reasonable charge determinations; they are required to recognize and use utilization review committees in hospitals and other medical organizations to the extent these are deemed effective by the PSRO. Safeguards, designed to protect the public interest and to prevent pro forma carrying out of review responsibilities, include appeals procedures.

Until January 1, 1976, the Secretary will be able to make an agreement only with a qualified organization representing a substantial proportion of the physicians in the designated geographical area. Until January 1, 1976, the Secretary is also required to poll the practicing physicians in the area--at the request of 10 percent or more of such physicians--to determine whether or not an organization of physicians that has requested an agreement with the Secretary to establish a PSRO substantially represents the area's practicing physicians. If more than 50 percent of the practicing physicians responding to the poll indicate that the organization does not substantially represent them, the Secretary cannot enter into an agreement with that organization. (Section 249F)

Level-of-care requirements in skilled nursing facilities.--The Medicare definition of covered extended-care services is broadened somewhat, and the same definition applies to skilled nursing facility services under Medicaid. Services covered are those provided directly by or requiring the supervision of skilled nursing personnel, or skilled rehabilitation services needed by the patient on a daily basis that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. Medicare coverage will also continue during short periods when no skilled services were actually provided but when discharge from a skilled facility for such brief period is neither desirable nor practical. This provision is applicable to services furnished after December 31, 1972. (Section 247)

Waiver of beneficiary liability in certain situations where Medicare claims are disallowed.--Medicare beneficiaries who were without fault will be relieved of liability for disallowed services where the disallowance is based on determinations that the services were not medically necessary or did not meet level-of-care requirements. Where the beneficiary is "held harmless," liability shifts either to Medicare or, where it is found that the provider has not acted with due care, to the provider. This provision is applicable to claims for services provided after the date of enactment. (Section 213)

Advance approval of extended care and home health coverage.--The Secretary is authorized to establish, by medical condition, specified periods of time after hospitalization during which a patient will be presumed to require an extended care level of services. Where a patient's physician certifies to the need for such care and submits to the skilled nursing facility, in advance of admission, a plan for carrying out the services, the care furnished will be assumed to be the type of care covered as extended care. Comparable provisions applying to posthospital home health services are also included. The advance approval provisions can, however, be declared inapplicable

to patients of any physician who is found to be unreliable in certifying patients' need for such care. In addition, a skilled nursing facility's utilization review committee can terminate payment to a patient during the approved period if it determines that further inpatient stay is no longer medically necessary. This provision is effective for admissions for extended care services or the initiation of home health plans on or after January 1, 1973. (Section 228)

Hospital insurance for the uninsured.--Persons reaching age 65 who are ineligible for hospital insurance may enroll, on a voluntary basis, for such coverage under the same conditions as for supplementary medical insurance. Those who enroll will pay the full cost of the protection--\$33 a month at the beginning and more in later years as hospital costs rise; enrollment for supplementary medical insurance is also required. States and public organizations, through agreements with the Secretary, may pay the premium for their aged retired (or active) employees. Coverage under this provision will be effective on July 1, 1973. (Section 202)

Medicare services outside the United States.--Inpatient hospital services furnished a resident of the United States in a foreign hospital that is closer or substantially more accessible to his residence than the nearest suitable United States hospital will be covered whether or not an emergency exists. Payments under SMI for necessary physicians and ambulance services furnished in connection with such hospitalization are also authorized. Medicare payments are also authorized for emergency inpatient hospital services and related physician and ambulance services needed by beneficiaries traveling in Canada between Alaska and another State. This provision applies to hospital admissions after December 31, 1972. (Section 211)

Elimination of provisions preventing enrollment under SMI more than 3 years after first opportunity.--Eligible persons may enroll under SMI during any prescribed enrollment period. Beneficiaries are no longer required to enroll within 3 years following first eligibility or a previous withdrawal from the program. The requirement that the SMI premium for late enrollees be increased 10 percent for each 12 months elapsing between the time they could have enrolled and actually do enroll is retained.

This provision is effective on enactment. It applies to all those ineligible to enroll because of the 3-year limit in effect under the old law. (Section 260)

Coordination between Medicare and Federal employees' plans.--Effective January 1, 1975, no payment will be made under Medicare for the same services covered under a Federal employees health benefits (FEHB) plan unless in the meantime the Secretary certifies that such plan or the FEHB program has been modified to make available

to Federal employees and retirees coverage supplementary to Medicare benefits and a contribution toward their health insurance premiums in an amount equal to the Government's contribution toward high option coverage. (Section 210)

Uniform Medicare and Medicaid standards for nursing facilities.--A single "skilled nursing facility" definition is established, as well as a single set of health, safety, environmental, and staffing standards for institutions formerly identified as extended care facilities under Medicare and skilled nursing homes under Medicaid. In the future, extended care services covered under Medicare will be provided in institutions identified as "skilled nursing facilities." Under both Medicare and Medicaid, a "skilled nursing facility" must meet the existing statutory conditions of participation for extended care facilities plus certain additional requirements that skilled nursing homes must meet under existing Medicaid law. Where a skilled nursing facility desires to participate under both Medicare and Medicaid, the Secretary's determination that it meets Medicare standards would also serve for Medicaid. Uniformity of standards will be effective July 1, 1973. (Section 246)

Reimbursement rates for skilled nursing facilities and intermediate care facilities.--States will be required to develop methods for reimbursing skilled nursing facilities and intermediate-care facilities on a basis reasonably related to cost and to implement these methods under Medicaid (after approval by the Secretary) by July 1, 1976. These State payment rates for skilled nursing facilities can then be used under Medicare in reimbursing for extended care services. The Medicaid rates can be adjusted upward, but not more than 10 percent, to account for specific factors related to Medicare not included by the State in computing Medicaid rates. (Section 249)

14-day-transfer requirement for posthospital extended care benefits.--The Medicare extended care benefit requirement that a patient's transfer to a skilled nursing facility take place within 14 days of his discharge from a hospital is modified to permit a longer interval for patients whose conditions do not permit provision of skilled services within 14 days (for example, a patient whose hip fracture has not mended to the point that physical therapy and restorative nursing can be utilized). An extension, not to exceed 2 weeks beyond the original 14 days, is authorized also in instances where admission to a facility providing extended care services is prevented because of a shortage of appropriate bed space in a geographic area. (Section 248)

Medical social services.--The Secretary may no longer require the provision of medical social services as a condition of participation for skilled nursing facilities under Medicare and Medicaid. (Section 265)

Waiver of registered nurse requirement in skilled nursing facilities in rural areas.--The Secretary may waive the requirement that a skilled nursing facility must employ a registered nurse full time (to the extent that "full time" is deemed to mean more than 40 hours a week) for certain rural skilled nursing facilities unable to assure the presence of a full-time registered nurse 7 days a week. A facility of this type that has one full-time registered nurse will be allowed a special waiver of the nursing requirement with respect to not more than two day shifts--over a weekend, for example. This special waiver will be authorized if the facility has only patients whose physicians have indicated that the individual can be without a registered nurse's services for a 48-hour period. If the facility has any patients for whom physicians have indicated a need for daily skilled nursing services, it must make arrangements for a registered nurse or a physician to spend enough time at the facility to provide the skilled services needed. (Section 267)

Amount of supplementary medical insurance premium.--The Secretary will continue to determine and promulgate in December 1972 and each year thereafter a monthly enrollee premium (applicable for both the aged and the disabled) for the following fiscal year. The enrollee premium will, however, be increased only in the event of a general benefit increase--either an automatic increase or one resulting from future legislation. In any given year, the premium will rise by no more than the percentage by which cash benefits have been increased across the board since the premium was last increased. Federal general revenues will finance that part of program costs not met through enrollee premiums.

The change is effective for the fiscal year beginning July 1973. (Through June 1973, the premium amount was \$5.80.) (Section 203)

Change in SMI deductible.--The SMI deductible is increased from \$50 to \$60 as of January 1, 1973. (Section 204)

Elimination of coinsurance payment with respect to home health services under SMI.--Payments for home health services furnished under SMI are to be in amounts equal to 100 percent of the reasonable cost of services, rather than 80 percent as in the old law. (Section 299K)

Automatic enrollment for SMI.--Aged and disabled beneficiaries, except for residents of Puerto Rico and foreign countries, will be automatically enrolled for SMI as they become entitled to hospital insurance. Persons eligible for automatic enrollment will, to the extent possible, be fully informed and given an opportunity to decline the coverage. This provision applies to any such individual whose initial enrollment period begins after March 31, 1973. (Section 206)

Coverage of chiropractors' services under SMI.--Coverage is provided for the services of licensed chiropractors who also meet uniform minimum standards, but only with respect to treatment by means of manual manipulation of the spine and only with respect to correction of subluxation of the spine demonstrated by X-ray. This provision will be effective July 1, 1973. (Section 273)

Limitation on Federal participation for capital expenditures.--The Secretary may withhold or reduce reimbursement amounts to providers of services under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, or other expenses related to capital expenditures for plant and equipment in excess of \$100,000, or which change the bed capacity, which substantially change the facilities' services, or which are determined to be inconsistent with State or local health facility plans. The Secretary will act on the basis of findings and recommendations submitted to him by various health facility planning agencies. If, after consultation with an appropriate national advisory council, the Secretary determines that a disallowance of expenses will discourage the operation or expansion of an organization that has demonstrated capability of economically providing comprehensive health care services or will otherwise be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he is authorized to allow such expenses. This provision is effective with respect to obligations for capital expenditures incurred after December 31, 1972, or earlier, if a State so requests. (Section 221)

Experiments and demonstration projects in prospective reimbursement and incentives for economy.--The Secretary is authorized to test various methods of making payment to providers of services on a prospective basis under the Medicare, Medicaid, and maternal and child health programs. In addition, he is authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy (including payment for services furnished by organizations providing comprehensive, mental, or ambulatory health care services, as well as ambulatory surgical centers); with performance incentives for intermediaries and carriers; with reimbursement implications of paying for services rendered by physicians' assistants; with the use of intermediate care and homemaker services by beneficiaries who either are ready for discharge from a hospital or are unable to maintain themselves at home without assistance; and with programs designed to improve the rehabilitation of patients in long-term health care facilities. The Secretary is also authorized to determine whether services of clinical psychologists might be made more generally available to persons eligible under Medicare and Medicaid. (Section 222)

Limitations on recognition of increase in prevailing charge levels for medical and other health services.--To determine the reasonableness of charges by physicians under Medicare, Medicaid, and maternal and child health programs: (a) after December 31, 1970, medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the calendar year elapsing before the start of the fiscal year; (b) for fiscal year 1974 and thereafter, the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (c) for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another. Charges allowed as reasonable after December 1972 may not exceed the lowest levels at which such supplies, equipment, and services are widely and consistently available in a locality. (Section 224)

Consultants for skilled nursing facilities.--

State agencies that are able and willing to do so could, with the Secretary's approval, furnish consultative services to skilled nursing facilities to enable them to meet Medicare requirements for use of consultants in certain specialty areas. Medicare payment would be made directly to the State agency for the cost of providing these consultative services. (Section 277)

Physical therapy and other therapy services under Medicare.--Beginning July 1, 1973, the services of a physical therapist in independent practice are covered under the supplementary medical insurance program when furnished in the therapist's office or the patient's home. Reimbursement would be based on not more than \$100 of incurred expenses in a calendar year.

Beginning January 1, 1973, a hospital or extended care facility may provide covered outpatient physical therapy services under the supplementary medical insurance program to its inpatients who have exhausted their days of hospital insurance coverage. In addition, payments to providers for the reasonable cost of physical therapy services furnished under arrangements with others will be limited to amounts equivalent to the salary and other costs that would have been payable if the services had been performed in an employment relationship, plus the cost of such expenses an individual not working as an employee might have, such as maintaining an office, travel expenses, and similar costs. (Section 251)

Coverage of speech pathology services under supplementary medical insurance program.--Outpatient speech pathology services furnished by approved providers of outpatient physical therapy are covered under the same requirements applicable to the coverage of outpatient physical therapy services, effective January 1, 1973. (Section 283)

Extension of grace period for termination of supplementary medical insurance coverage where failure to pay premiums is due to good cause.--The 90-day grace period is extended for an additional 90 days where the Secretary finds there is good cause for failure to pay the premium before the expiration of the initial 90-day grace period. This provision applies to cases of nonpayment of premiums due within the 90-day period preceding the date of enactment. (Section 257)

Extension of time for filing claim for supplementary medical insurance benefits where delay is due to administrative error.--Supplementary medical insurance benefits may be paid to the beneficiary when a claim is not filed timely due to an administrative error. This provision assures that claimants will not be treated inequitably because of such an error and applies to bills submitted and requests for payment made after March 1968. (Section 258)

Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction.--The Secretary is authorized to provide equitable relief in situations where an individual's enrollment or nonenrollment in part B of Medicare is other than it should be because of administrative error, misrepresentation, or inaction on the part of an officer, employee, or agent of the Federal Government. (Section 259)

Requirement of minimum amount of claim to establish entitlement to hearing under supplementary medical insurance program.--Carriers are required to hold fair hearings in response to disagreements over amounts paid under supplementary medical insurance only when the amount in controversy is \$100 or more.

This provision applies to hearings requested after enactment of these amendments. (Section 262)

Collection of supplementary medical insurance premiums from individuals entitled to both social security and railroad retirement benefits.--The Railroad Retirement Board is made responsible for collecting supplementary medical insurance premiums for enrollees entitled under that program. The Railroad Retirement Board is authorized to contract with a carrier or carriers for purposes of servicing its beneficiaries with respect to part B benefits. This provision applies to premiums becoming due and payable after the 4th month after the month of enactment. (Section 263)

Refund of excess premiums under Medicare.--Provision is made for the refund of hospital insurance or supplementary medical insurance premiums paid by or on behalf of a deceased individual for months after the month of death. Refund is to the person who paid the premiums, the legal representative of the estate, or other survivor, as appropriate. (Section 266)

Payment for prosthetic lenses under the supplementary medical insurance program.--Licensed optometrists are recognized as "physicians" under Medicare, but only for the purposes of attesting to a beneficiary's need for prosthetic lenses, thus permitting payment for such lenses ordered by an optometrist. This change does not provide for the coverage of services not covered under present law. (Section 264)

Coverage of supplies related to colostomies.--Effective upon enactment, colostomy bags and supplies directly related to colostomy care are covered as prosthetic devices under the supplementary medical insurance program. (Section 252)

Payment for supervisory physicians in teaching hospitals.--Teaching physicians in hospitals must be reimbursed on a cost basis for services to patients unless (1) the patient is a bona fide private patient, or (2) the hospital has customarily charged all patients, and collected from a majority of them, on a fee-for-service basis. Also, a hospital will be permitted to include among its reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as hospital services.

Reimbursement on a cost basis under part A is authorized for services furnished by an intern or resident in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

The amendment with respect to supervisory physicians' in teaching hospitals is effective for accounting periods beginning after June 30, 1973. The provision relating to the services of podiatric interns and residents is effective with respect to accounting periods beginning after December 31, 1972. (Section 227)

Limits on costs recognized as reasonable.--The Secretary is authorized to limit provider costs to be recognized as reasonable under Medicare based on comparisons of the cost of covered services by various classes of providers in the same geographical area. For other than emergency care, hospitals and skilled nursing facilities could charge beneficiaries for the costs of services in excess of those found necessary to the efficient delivery of needed health services

(except in the case of an admission by a physician who has a financial interest in the facility). This provision is effective for accounting periods beginning after June 30, 1973. (Section 223)

Authority to terminate payments to suppliers of services.--The Secretary is authorized to terminate or suspend payments under the Medicare program for services rendered by any supplier of health and medical services found guilty of program abuses. The Secretary is required to make the names of such persons or organizations public so that beneficiaries will be informed of those which cannot participate in the program. The situations for which termination of payment will be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Also, there will be no Federal financial participation in any expenditure under the Medicaid and maternal and child health programs by the State with respect to services furnished by a supplier to whom the Secretary would not make Medicare payments under this provision of the bill. Program review teams will be established to furnish professional advice to the Secretary in carrying out this authority. Any person or organization dissatisfied with the Secretary's decision to terminate payments will be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision. (Section 229)

Validation of surveys made by the Joint Commission on the Accreditation of Hospitals in Medicare.--The Secretary is authorized to enter into an agreement with any State under which the State certifying agency would survey hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) on a selective and limited basis, or would survey a specific hospital where the Secretary finds that a survey, or more limited investigation, is appropriate because he has received a substantial allegation, with evidence, of the existence of a condition significantly adverse to patient health or safety. These sample and special surveys will serve as a mechanism to validate the JCAH survey process. If, in the course of such a survey, an institution is found to have significant deficiencies, following timely discussion of such deficiencies with the JCAH, the detailed Medicare standards and compliance procedures will be applied in place of the general JCAH standards. The Secretary is authorized, after consultation with the JCAH, to promulgate standards, as necessary for health and safety, which may be higher or more precise than those of the JCAH and which all hospitals would have to meet after appropriate and adequate time for compliance. (Section 244)

Government payment no higher than charges.--Effective for accounting periods beginning after 1972, payment for institutional services under the Medicare, Medicaid, and maternal and child health programs may, generally, not be higher than the charges regularly made for these services. (Section 233)

Institutional planning.--Each provider of services is required, as a condition of participation under Medicare, to have a written plan reflecting an operating budget and a capital expenditures budget covering the immediate subsequent one and three accounting years. The plan, which will be reviewed and updated annually, is expected to contain information outlining the services to be provided in the future, the estimated costs of providing such services (including proposed capital expenditures in excess of \$100,000 for acquisition or improvement of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and proposed methods of financing the costs. This provision is effective for a provider of services for any fiscal year beginning after the 5th month following the month of enactment. (Section 234)

Prohibition against reassignment of claims.--Payment under Medicare and Medicaid to anyone other than the patient, his physician, or other person who provided the service is prohibited unless the physician or other person is required as a condition of his employment to turn over his fees to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. Direct payment could, however, be made to a foundation or other organization which provides and administers health care through an organized health care delivery system. This provision is effective with respect to bills submitted after enactment for Medicare, and for Medicaid it will be effective January 1, 1973, or earlier, if the State plan so provides. (Section 236)

Notification of unnecessary admission to a hospital or extended care facility.--The responsibility of hospital and skilled nursing facility utilization review committees is expanded to require notification in any case which, in the course of a review of a current sample of admissions, it is determined that admission to or further stay in the institution is not medically necessary. Payment would be terminated under the same procedures now applied to cases of extended duration where the committee determines that further stay is not medically necessary. (Section 238)

Hospital admissions for dental services.--A certification of medical necessity is required to be made where a patient must be hospitalized in connection with a dental procedure for management of other severe impairments. The dentist who is caring for a patient may make the determination that such hospitalization is necessary without corroborating certification by a physician. Hospital stays under this provision will be covered effective with admissions after the 2nd month following the month of enactment. (Section 256)

Institutional planning.--Each provider of services is required, as a condition of participation under Medicare, to have a written plan reflecting an operating budget and a capital expenditures budget covering the immediate subsequent one and three accounting years. The plan, which will be reviewed and updated annually, is expected to contain information outlining the services to be provided in the future, the estimated costs of providing such services (including proposed capital expenditures in excess of \$100,000 for acquisition or improvement of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and proposed methods of financing the costs. This provision is effective for a provider of services for any fiscal year beginning after the 5th month following the month of enactment. (Section 234)

Prohibition against reassignment of claims.--Payment under Medicare and Medicaid to anyone other than the patient, his physician, or other person who provided the service is prohibited unless the physician or other person is required as a condition of his employment to turn over his fees to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. Direct payment could, however, be made to a foundation or other organization which provides and administers health care through an organized health care delivery system. This provision is effective with respect to bills submitted after enactment for Medicare, and for Medicaid it will be effective January 1, 1973, or earlier, if the State plan so provides. (Section 236)

Notification of unnecessary admission to a hospital or extended care facility.--The responsibility of hospital and skilled nursing facility utilization review committees is expanded to require notification in any case which, in the course of a review of a current sample of admissions, it is determined that admission to or further stay in the institution is not medically necessary. Payment would be terminated under the same procedures now applied to cases of extended duration where the committee determines that further stay is not medically necessary. (Section 238)

Hospital admissions for dental services.--A certification of medical necessity is required to be made where a patient must be hospitalized in connection with a dental procedure for management of other severe impairments. The dentist who is caring for a patient may make the determination that such hospitalization is necessary without corroborating certification by a physician. Hospital stays under this provision will be covered effective with admissions after the 2nd month following the month of enactment. (Section 256)

Durable medical equipment.--The Secretary is authorized to experiment with reimbursement approaches designed to prevent unreasonable expenses to Medicare resulting from prolonged rentals (rather than purchase) of durable medical equipment and to implement without further legislation any purchase approach found to be workable, desirable, and economical. (Section 245)

Penalties for fraudulent acts and false reporting under Medicare and Medicaid.--Present penalty provisions relating to the making of a false statement or representation of a material fact in any application for Medicare or Medicaid payments are broadened to include the soliciting, offering, or acceptance of kickbacks or bribes by providers of health care services; concealment or failure to disclose an event affecting a person's right to benefits with intent to defraud; or converting benefit payments to improper use. The penalty for such acts is imprisonment up to one year, a fine of \$10,000, or both. Similarly, anyone who knowingly and willfully makes a false statement of material fact with respect to the conditions and operation of a facility or agency to secure Medicare or Medicaid certification or recertification would be guilty of a misdemeanor punishable by up to 6 months' imprisonment, a fine of not more than \$2,000, or both. (Section 242)

Proficiency testing for health personnel.--The Secretary (in conjunction with appropriate professional health organizations and State health and licensure agencies) is required to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present Medicare regulations. Such testing program is to be applied through December 31, 1977, after which persons entering the health care fields in question would need to meet the regular formal education, professional membership, or other requirements. (Section 241)

Provider Reimbursement Review Board.--A Provider Reimbursement Review Board is established to review disputes between an intermediary and a provider concerning the intermediary's final determination (or failure to make a timely final determination) on a properly filed cost report, where the amount in controversy is at least \$10,000. Groups of providers could appeal to the Board on common issues where the amounts in controversy aggregate \$50,000 or more. Decisions of the Board would be final unless the Secretary reverses the Board's decision within 60 days, in which case the provider would have the right to judicial review. The provision is effective with respect to cost reports for accounting periods ending on or after June 30, 1973. (Section 243)

Withholding of Federal Medicaid matching amounts for certain terminated Medicare providers.--The Secretary is authorized to withhold (subsequent to 60 days notice to a State) future Federal Medicaid payments with respect to institutions which have withdrawn from Medicare without refunding Medicare overpayments or submitting cost reports to account for Medicare payments to them during their participation in that program. (Section 290)

Authority of Secretary to administer oaths and affirmations in Medicare proceedings.--The Secretary, in carrying out his responsibility for administration of the Medicare program is authorized to administer oaths and affirmations in the course of any hearing, investigation, or other proceeding. (Section 289)

Appeals and judicial review under Medicare.--Previous law is clarified by a provision specifying that there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B and that insofar as the amount of benefits under part A is involved, such an appeal is authorized only if the amount in controversy is \$1,000 or more. (Section 2990)

Disclosure of information concerning performance of carriers, intermediaries, State agencies, and providers of services.--The Secretary is required to make public the following types of evaluations and reports: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews; (2) comparative evaluations of the performance of contractors--including comparisons of either overall performance or of any particular contractor operations; (3) program validation survey reports--with the names of individuals deleted. Contractors or providers being evaluated will be given reasonable opportunity to review and comment on such reports; pertinent parts of their comments will be incorporated in the reports. This provision applies to reports which are completed by the Secretary after the 3rd calendar month following enactment. (Section 249C)

Public disclosure of surveys of providers.--The Secretary is required to make available to the public information from surveys of providers relating to the presence or absence of deficiencies in areas such as staffing, fire safety, and sanitation. Following completion of a survey of a health care facility or organization, those portions of the survey findings relating to statutory requirements as well as major additional health and safety requirements will be matters of public record. In the case of Medicare, such information will be available for inspection within 90 days of completion of the survey upon request in social security district offices and, in the case of Medicaid, the information will be available in local welfare offices. The provision is effective 6 months following enactment. (Section 299D)

Waiver of recovery of incorrect payments from survivor who is without fault under Medicare.--Where a survivor is liable for payment of a Medicare overpayment to a deceased beneficiary, recovery of the overpaid amount may be waived if the survivor is without fault in incurring the overpayment. This provision applies to overpayments outstanding at the time of enactment. (Section 261)

Waiver of recovery of erroneous payment.--Medicare's right of recovery of an erroneous payment is limited to a 3-year period from the date of the payment, where the institution or person involved acted in good faith. Similarly, the Secretary would specify a reasonable period of time (not to exceed 3 years) after which Medicare would not be required to accept claims for underpayment or nonpayment. The limit on right of recovery applies to notices of payment sent after 1968. The limit on filing claims applies to services furnished after 1970. (Section 281)

Payment to laboratories under the supplementary medical insurance program for diagnostic tests.--The Secretary is authorized, with respect to diagnostic laboratory tests for which payment is to be made to a laboratory on the basis of an assignment by the beneficiary, to negotiate a payment rate with the laboratory which would be considered the full charge for such tests. Reimbursement would be made at 100 percent of such negotiated rate, which would be limited to an amount not exceeding the payment that would have been made in the absence of such rate. (Section 279)

Modification of role of the Health Insurance Benefits Advisory Council.--The role of the Health Insurance Benefits Advisory Council is limited to that of advising the Secretary on matters of general policy in the administration of Medicare. (Section 288)

Financing.--Consistent with past policy of maintaining the social security program on a sound financial basis, provision is made for meeting the cost of the expanded program. The costs of the cash benefits program and the hospital insurance program are to be financed by revised contribution rate schedules. For 1973, the combined contribution rate for cash benefits and hospital insurance is increased from the previously scheduled 5.5 percent each for employers and employees to 5.85 percent each. The provisions relating to the earnings base for tax and benefit purposes in the law (as amended in July 1972) are retained: the maximums of \$10,800 for 1973 and of \$12,000 for 1974, with automatic increases thereafter as wages rise. The cost estimates underlying the contribution rates were based on the new financing principles adopted earlier in 1972 under Public law 92-336.

As a result of the 1972 Amendments, a serious actuarial imbalance in the financing of the hospital program of -0.63% of payroll was eliminated and the program placed on a sound financial basis. P.L. 92-336 increased the contribution rates in future years and the earnings bases to which they would apply by enough to raise the actuarial balance to +0.01% of payroll. P.L. 92-603 fully financed all improvements in program benefits, so that the actuarial balance of the program remains +0.01% of payroll. Also under both of these acts explicit provision is made for increasing the wage base to which the contribution rates apply according to the increase in average earnings in employment covered by Social Security. The financing of the hospital insurance program had always been set under the assumption that such adjustments would be made. The tax rates under previous law, under P.L. 92-336, and under P.L. 92-603 are shown in the following table.

#### Contribution Rates

<u>Calendar Year</u>	<u>Employer, employee and self-employed rate, each</u>		
	<u>Previous Law</u>	<u>Public Law 92-336</u>	<u>Public Law 92-603</u>
1972	0.60%	0.60%	0.60%
1973-75	.65	.90	1.00
1976-77	.70	.90	1.00
1978-79	.70	1.00	1.25
1980	.80	1.00	1.25
1981-85	.80	1.00	1.35
1986	.80	1.10	1.45
1987-92	.90	1.10	1.45
1993-97	.90	1.20	1.45

#### Earnings Bases

1972	\$9,000	9,000	9,000
1973	9,000	10,800	10,800
1974	9,000	12,000	12,000

A discussion of the financial status of program is available in the Annual Report of the Board of Trustees of the Hospital Insurance program. Discussion of the specific effect of P.L. 92-336 and P.L. 92-603 on the financial status of the program can be found in "Actuarial Cost Estimates for the Old-age, Survivors, Disability, and Hospital Insurance System as modified by the Social Security Provision of Public Law 92-336," published by the Office of the Actuary, Social Security Administration, September 1972, and in a similar publication, "Actuarial Cost Estimates for the Old-age, Survivors, Disability, Hospital, and Supplementary Medical Insurance Systems as modified by Public Law 92-603," prepared for use of the House Committee on Ways and Means by the Office of the Actuary, Social Security Administration, March 2, 1973.

APPENDIX D

ADMINISTRATIVE STRUCTURE OF THE MEDICARE PROGRAM

## ADMINISTRATIVE STRUCTURE OF THE MEDICARE PROGRAM

Overall responsibility for administration of Medicare is vested by law in the Secretary of Health, Education, and Welfare. The statute also provides for significant participation in certain areas of administration by private organizations and public agencies.

Within the Department of Health, Education, and Welfare, primary responsibility for administering the Medicare program is assigned to the Social Security Administration (SSA). Special responsibilities in connection with the health care standards of Medicare have been assigned to the Public Health Service, and certain responsibilities regarding relations between Medicare and State medical assistance programs are coordinated by SSA and the Social and Rehabilitation Service. Responsibility for assuring compliance by participating health care facilities with Title VI of the Civil Rights Act of 1964 is assigned to the Office of Civil Rights of the Department.

### Role of the Social Security Administration

The Social Security Administration negotiates and administers agreements with the intermediaries and carriers which perform payment and other program functions; with the State agencies which certify health facilities for participation in the program; and with hospitals and other institutions which provide services for which the program makes reimbursement; develops reimbursement principles and guidelines; works with the Public Health Service in the formulation and periodic review of the conditions of participation; formulates Medicare regulations; develops program policy and procedural instructions; and performs the basic recordkeeping and data processing functions required for administration of the program. Within SSA, the Bureau of Health Insurance has responsibility for the formulation of policies and procedures and for the overall administration of the health insurance program.<sup>1/</sup>

In addition to the Bureau of Health Insurance, many other SSA components have substantial program responsibilities. SSA's field organization--including approximately 1,000 district and branch offices, and more than 3,000 contact stations throughout the country--carries out enrollment activities and serves as a readily accessible source of program information and direct service to

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<sup>1/</sup> During FY 1973, the Department began examining ways in which the policy role of the Assistant Secretary for Health can be strengthened in the Medicare and Medicaid programs. Organizational changes made necessary by that examination will be covered in the next annual report.

beneficiaries, the professional community, and the general public. In addition, district offices perform certain claims development and investigative activities for Medicare carriers and intermediaries.

The Office of Research and Statistics collects data on program operations and carries out analytical studies designed to evaluate the program and measure its performance.

The Office of the Actuary has responsibility for the actuarial evaluation of the hospital insurance and medical insurance programs, including the preparation of the actuarial estimates used in setting the medical insurance premium and hospital insurance deductible and coinsurance amounts.<sup>2/</sup>

The Office of Public Affairs which has primary responsibility for developing and coordinating SSA's information activities, works with the Bureau of Health Insurance in the preparation of exhibits, films, visual aids, booklets and other materials needed to inform the general public, as well as special professional audiences, about program benefits and requirements and claims procedures.

The Bureau of Data Processing, through its electronic data processing capabilities, maintains the millions of records on beneficiary eligibility, utilization of covered services, and deductible status. The Bureau also sends premium notices to, and maintains records on the payment of medical insurance premiums by the approximately 3.25 million enrollees who make direct payments or for whom premium payment is made through State agency "buy-in" arrangements or through private retirement groups.

An insurance compliance staff in the Office of Administration assures that the intermediaries and carriers assisting in the administration of Medicare fully comply with equal employment opportunity requirements.

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<sup>2/</sup> The Office of the Actuary also has responsibility for preparing the actuarial estimates used in setting the hospital insurance premium applicable to uninsured individuals eligible to enroll in the hospital insurance program under the provisions of Section 202 of P.L. 92-603.

## Role of the Health Services and Mental Health Administration (HSMHA)<sup>3/</sup>

The Health Services and Mental Health Administration (both at its headquarters and in its regional offices) acts as a primary resource regarding professional health aspects of the Medicare program, participating with the Social Security Administration in formulating and revising the conditions of participation for providers of services, developing policies on the role of State agencies, providing assistance to the State agencies in carrying out their Medicare responsibilities, supporting and evaluating experimental approaches to utilization review and providing professional advice in many technical and medical areas of program administration.

### Role of the Social and Rehabilitation Service

The Social and Rehabilitation Service collaborates with the Social Security Administration and the Public Health Service in those aspects of program planning, coordination, and evaluation involving the interrelationships of the health insurance program with State public assistance and medical assistance programs. In addition, the Social and Rehabilitation Service provides consultation and general and technical assistance to State agencies administering medical assistance programs to assure effective coordination between Medicare and the programs at the State level.

### Role of the Office of Civil Rights

Title VI of the Civil Rights Act of 1964 provides that no institution agency or activity receiving Federal financial assistance may engage in discriminatory practice on the basis of race, color or national origin. Thus before any hospital, skilled nursing facility or home health agency may become a provider under Medicare, its compliance with the provisions of title VI must be assured. The Department's Office of Civil Rights determines whether Medicare providers meet this requirement and investigates complaints of discrimination.

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<sup>3/</sup> A reorganization of the Department's health agencies in May 1973 had the effect of abolishing HSMHA and distributing its functions elsewhere. A new Health Services Administration was created and assigned HSMHA's health service grant and direct delivery programs. In addition, a new Health Resources Administration was given the health services research, data gathering, surveillance activities and health service demonstration programs from HSMHA as well as the Bureau of Health Manpower Education from NIH. The Center for Disease Control was made a free-standing agency for preventive health activities with the National Institute for Occupational Safety and Health under its administrative direction. In September 1973 the National Institute of Mental Health was combined with the National Institute for Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to form the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). ADAMHA is the sixth agency of the Public Health Service; the other five agencies which report to the Assistant Secretary for Health and which comprise the Public Health Service are: the Food and Drug Administration, the National Institutes of Health, the Health Services Administration, the Health Resources Administration, and the Center for Disease Control.

#### Role of the State Agencies<sup>4/</sup>

The law requires that, wherever possible, the Secretary use the services of appropriate State or local health agencies or other appropriate State or local agencies in determining whether providers of services and independent laboratories meet the conditions for participation in the Medicare program. All 54 jurisdictions (including the District of Columbia, Puerto Rico, the Virgin Islands and Guam) have designated agencies--in most instances State health agencies--to perform this function.

In carrying out their Medicare responsibilities, State agencies conduct field surveys of institutions and agencies to determine the extent to which they meet the conditions of participation, undertake periodic resurveys of participating facilities to determine whether they continue to meet such conditions, provide consultative services to facilities experiencing difficulties in meeting the participation requirements, identify nonparticipating hospitals which can be reimbursed under the program for emergency services and coordinate activities under the health insurance program with activities under medical assistance programs. The State agencies are reimbursed for the costs of activities they perform in the program including related costs of administrative overhead and staff.

#### Role of the Intermediaries<sup>5/</sup>

Participating hospitals, skilled nursing facilities, and home health agencies may receive reimbursement either through a fiscal intermediary, or if they prefer, directly from the Government. Virtually all providers have chosen to use intermediaries. Under agreements with the Secretary, intermediaries are responsible for determining the reasonable costs of services provided beneficiaries and for reimbursing providers on behalf of the program. They may also process the Part B claims of the providers of services which they service. In addition, the agreements authorize intermediaries to provide consultative services to providers, audit provider records, and perform related functions. All agreements also require that intermediaries assist providers in establishing and applying safeguards against unnecessary use of services covered by the program. As of June 30, 1972, the Blue Cross Association (with subcontracts to 73 Blue Cross Plans), 5 commercial health insurers, and

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<sup>4/</sup> A list of State agencies having agreements with the Secretary of Health, Education, and Welfare under the Medicare program follows in this Appendix as Exhibit 1.

<sup>5/</sup> A list of intermediaries and carriers operating under agreements with the Secretary of Health, Education, and Welfare follows in this Appendix as Exhibit 2.

4 independent insurers were operating as fiscal intermediaries on behalf of over 13,200 participating providers and 2,900 independent laboratories. Further, 213 hospitals, 86 skilled nursing facilities, 391 home health agencies and 6 rehabilitation agencies were submitting bills directly to SSA.

#### Role of the Carriers <sup>6/</sup>

The Secretary is authorized by law to contract, to the extent possible, with nongovernmental organizations to serve as carriers for the medical insurance program. To qualify for consideration as a Medicare carrier such an organization must be engaged in providing, paying for, or reimbursing the cost of health services under group insurance policies or similar group arrangements, in return for premiums or other periodic charges. As of June 30, 1972, there were 33 Blue Shield plans, 13 insurance companies, 1 independent health insurer and 1 State agency operating as carriers.

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<sup>6/</sup> A list of intermediaries and carriers operating under agreements with the Secretary of Health, Education, and Welfare follows in this Appendix as Exhibit 2.

STATE AGENCIES ADMINISTERING PROVIDER CERTIFICATION

ALABAMA: State Department of Public Health, Montgomery, Alabama

ALASKA: Alaska Department of Health and Welfare, Juneau, Alaska

ARIZONA: State Department of Health, Phoenix, Arizona

ARKANSAS: State Department of Health, Little Rock, Arkansas

CALIFORNIA: State Department of Public Health, Sacramento, California

COLORADO: Department of Public Health, Denver, Colorado

CONNECTICUT: State Department of Health, Hartford, Connecticut

DELAWARE: State Board of Health, Dover, Delaware

DISTRICT OF COLUMBIA: District of Columbia Department of Public Health,  
Washington, D.C.

FLORIDA: State Board of Health, Jacksonville, Florida

GEORGIA: Georgia Department of Public Health, Atlanta, Georgia

GUAM: Department of Public Health and Social Services, Agana, Guam

HAWAII: Hawaii Department of Health, Honolulu, Hawaii

IDAHO: Idaho Department of Health, Boise, Idaho

ILLINOIS: Illinois Department of Public Health, Springfield, Illinois

INDIANA: State Board of Health, Indianapolis, Indiana

IOWA: State Department of Health, Des Moines, Iowa

KANSAS: State Board of Health, Topeka, Kansas

KENTUCKY: Commonwealth of Kentucky State Department of Health, Frankfort,  
Kentucky

LOUISIANA: Louisiana Department of Hospitals, Baton Rouge, Louisiana

MAINE: Maine Department of Health and Welfare, Augusta, Maine

MARYLAND: State Department of Health, Baltimore, Maryland

MASSACHUSETTS: Massachusetts Department of Public Health, Boston, Mass.

MICHIGAN: Michigan Department of Health, Lansing, Michigan

MINNESOTA: State Department of Health, Minneapolis, Minnesota

MISSISSIPPI: Mississippi State Board of Health, Jackson, Mississippi

MISSOURI: State Division of Health, Jefferson City, Missouri

MONTANA: State Department of Health, Helena, Montana

NEBRASKA: State Department of Health, Lincoln, Nebraska

NEVADA: Department of Health, Welfare and Rehabilitation, Carson City, Nevada

NEW HAMPSHIRE: New Hampshire Division of Public Health, Concord, N.H.

NEW JERSEY: State Department of Health, Trenton, New Jersey

NEW MEXICO: New Mexico Health and Social Services, Santa Fe, New Mexico

NEW YORK: New York State Department of Health, Albany, New York

NORTH CAROLINA: State Board of Health, Raleigh, North Carolina

NORTH DAKOTA: State Department of Health, Bismark, North Dakota

OHIO: Ohio Department of Health, Columbus, Ohio

OKLAHOMA: State Department of Health, Oklahoma City, Oklahoma

OREGON: State Board of Health, Portland, Oregon

PENNSYLVANIA: Department of Health, Harrisburg, Pennsylvania

PUERTO RICO: Puerto Rico Department of Health, San Juan, Puerto Rico

RHODE ISLAND: Rhode Island Department of Health, Providence, Rhode Island

SOUTH CAROLINA: State Board of Health, Columbia, South Carolina

SOUTH DAKOTA: State Department of Health, Pierre, South Dakota

TENNESSEE: Tennessee Department of Public Health, Nashville, Tennessee

TEXAS: State Department of Health, Austin, Texas

UTAH: State Department of Health, Salt Lake City, Utah

VERMONT: Vermont Department of Health, Burlington, Vermont

VIRGIN ISLANDS: Virgin Islands Department of Health, St. Thomas, V.I.

VIRGINIA: State Department of Health, Richmond, Virginia

WASHINGTON: State Department of Health, Olympia, Washington

WEST VIRGINIA: State Health Department, Charleston, West Virginia

WISCONSIN: State Board of Health, Madison, Wisconsin

WYOMING: State Department of Public Health, Cheyenne, Wyoming

# INTERMEDIARIES AND CARRIERS WHICH PROCESS MEDICARE CLAIMS\*

## PART A—HOSPITAL INSURANCE

**Alabama**  
Blue Cross-Blue Shield of Alabama,  
930 South 20th Street, Birmingham,  
Ala.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>

**Alaska**  
Blue Cross Washington-Alaska, Inc.,  
601 Broadway, Post Office Box 527, Se-  
attle, Wash.

**Arizona**  
Associated Hospital Service of Ari-  
zona, 331 West Indian School Road,  
Post Office Box 13466, Phoenix, Ariz.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>

## PART B—MEDICAL INSURANCE

**Alabama**  
Blue Cross-Blue Shield of Alabama,  
930 South 20th Street, Birmingham,  
Ala.

**Alaska**  
Aetna Life and Casualty, 522 South-  
west Fifth Avenue, Portland, Oreg.

**Arizona**  
Aetna Life and Casualty, 3010 West  
Fairmont Avenue, Phoenix, Ariz.

**Arkansas**  
Arkansas Blue Cross and Blue Shield,  
Post Office Box 2181, Little Rock, Ark.

**California**  
Blue Cross of Southern California,  
4777 Sunset Boulevard, Los Angeles,  
Calif.  
Hospital Service of California, 1919  
Welster Street, Oakland, Calif.  
Aetna Life and Casualty.<sup>1</sup>  
The Travelers Insurance Co.<sup>2</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>  
Kaiser Foundation Health Plan, Inc.<sup>4</sup>

**Colorado**  
Colorado Hospital Service, 655 Broad-  
way, Denver, Colo.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>

**Connecticut**  
Connecticut Blue Cross, Inc., 345  
Whitney Avenue, New Haven, Conn.  
Aetna Life and Casualty.<sup>1</sup>  
The Travelers Insurance Co.<sup>2</sup>

**Delaware**  
Blue Cross and Blue Shield of Dela-  
ware, 201 West 14th Street, William-  
ton, Del.

**Florida**  
Blue Cross of Florida, Inc., Post Of-  
fice Box 2711, Jacksonville, Fla.  
Aetna Life and Casualty.<sup>1</sup>  
The Travelers Insurance Co.<sup>2</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>

**Georgia**  
United Hospitals Service Association,  
1010 Peachtree Street N.W., Atlanta, Ga.  
Georgia Hospital Service Association,  
Inc., 2357 Warm Springs Road, Post Of-  
fice Box 1520, Columbus, Ga.  
The Travelers Insurance Co.<sup>2</sup>

**Hawaii**  
Hawaii Medical Service Association,  
Post Office Box 560, Honolulu, Hawaii.  
Kaiser Foundation Health Plan, Inc.<sup>4</sup>

**Idaho**  
Idaho Hospital Service, Inc., 1501  
Federal Way, Boise, Idaho.  
Mutual of Omaha Insurance Co.<sup>2</sup>

**Illinois**  
Hospital Service Corp., 222 North  
Dearborn Street, Chicago, Ill.  
Illinois Hospital and Health Service,  
Inc., 227 North Wyman Street, Rock-  
ford, Ill.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>

**Indiana**  
Blue Cross Hospital Service, 120 West  
Market Street, Indianapolis, Ind.  
Aetna Life and Casualty.<sup>1</sup>

**Iowa**  
Hospital Service, Inc. of Iowa, Liber-  
ty Building, Des Moines, Iowa.  
Associated Hospitals Service, Inc.,  
1622 Pierce Street, Sioux City, Iowa.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>

**Kansas**  
Kansas Hospital Service Association,  
Inc., 1123 Topeka Boulevard, Topeka,  
Kans.  
Blue Cross of Kansas City, 3637  
Broadway, P.O. Box 169, Kansas City,  
Mo.

**Kentucky**  
Blue Cross Hospital Plan, Inc., 3101  
Bardstown Road, Louisville, Ky.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>

**Louisiana**  
Louisiana Hospital Service, Inc.,  
10255 Florida Boulevard, Baton Rouge,  
La.  
Hospital Service Association of New  
Orleans, 2026 St. Charles Avenue, New  
Orleans, La.  
Aetna Life and Casualty.<sup>1</sup>

## PART A—HOSPITAL INSURANCE—CON.

**District of Columbia**  
Group Hospitalization, Inc., 550 12th  
Street S.W., Washington, D.C.  
Mutual of Omaha Insurance Co.<sup>2</sup>

**Florida**  
Blue Cross of Florida, Inc., Post Of-  
fice Box 2711, Jacksonville, Fla.  
Aetna Life and Casualty.<sup>1</sup>  
The Travelers Insurance Co.<sup>2</sup>  
Mutual of Omaha Insurance Co.<sup>2</sup>

## PART B—MEDICAL INSURANCE—CON.

**District of Columbia**  
Medical Service of D.C., 550 12th  
Street S.W., Washington, D.C.

**Florida**  
The Prudential Insurance Company  
of America, Medicare Part B, Post Of-  
fice Box 7340, Station C, Atlanta, Ga.

**Hawaii**  
Aetna Life and Casualty, Kuaaleo-  
lani Building, 116 South King Street,  
Honolulu, Hawaii.

**Idaho**  
The Equitable Life Assurance So-  
ciety, Post Office Box 8048, Boise, Idaho.

**Illinois**  
County of Cook.  
Illinois Medical Service, 222 North  
Dearborn Street, Chicago, Ill.  
Rest of State: Continental Casualty  
Co., 310 South Michigan Avenue, Chi-  
cago, Ill.

**Indiana**  
Mutual Medical Insurance, Inc., 120  
West Market Street, Indianapolis, Ind.

**Iowa**  
Iowa Medical Service, 324 Liberty  
Building, Des Moines, Iowa.

**Kansas**  
Counties of: Johnson, Wyandotte,  
Jaye Shield of Kansas City, I.O.  
Box 169, Kansas City Mo.  
Rest of State: Kansas Blue Shield,  
1133 Topeka Boulevard, Topeka, Kans.

**Kentucky**  
Metropolitan Life Insurance Co., 1218  
Harrodsburg Road, Lexington, Ky.

**Louisiana**  
Pan American Life Insurance Co.,  
P.O. Box 60450, New Orleans, La.

PART A—HOSPITAL INSURANCE—CON.

**Maine**  
Associated Hospital Service of Maine,  
110 Free Street, Portland, Maine.  
The Travelers Insurance Co.<sup>2</sup>

**Maryland**  
Maryland Blue Cross, Inc., 700 East  
Joppa Road, Baltimore, Md.  
Group Hospitalization, Inc., 550 12th  
Street SW., Washington, D.C.  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Massachusetts**  
Massachusetts Blue Cross, Inc., 133  
Federal Street, Boston, Mass.  
Aetna Life and Casualty.<sup>1</sup>  
The Travelers Insurance Co.<sup>2</sup>

**Michigan**  
Michigan Hospital Service, 600 Lafayette  
East, Detroit, Mich.  
The Travelers Insurance Co.<sup>2</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Minnesota**  
Blue Cross and Blue Shield of Minne-  
sota, 3535 Blue Cross Road, St. Paul,  
Minn.  
Aetna Life and Casualty.<sup>1</sup>  
The Travelers Insurance Co.<sup>2</sup>  
Rest of State: Maryland Medical  
Service, Inc., 700 East Joppa Road, Bal-  
timore, Md.

**Mississippi**  
Mississippi Hospital and Medical  
Service, P.O. Box 3614, Jackson, Miss.  
Mutual of Omaha Insurance Com-  
pany.<sup>3</sup>

**Missouri**  
Blue Cross Hospital Service, Inc. of  
Missouri, 1430 Olive Street, St. Louis,  
Mo.  
Blue Cross of Kansas City, 3637  
Broadway, P.O. Box 169, Kansas City,  
Mo.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Montana**  
Blue Cross of Montana, 3360 10th  
Avenue, South, Great Falls, Mont.  
The Travelers Insurance Co.<sup>2</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Nebraska**  
Nebraska Blue Cross, P.O. Box 3248,  
Main Post Office Station, Omaha, Neb.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Nevada**  
Aetna Life and Casualty, P.O. Box 3077,  
Reno, Nev.  
Mutual of Omaha Insurance Co.<sup>3</sup>

PART B—MEDICAL INSURANCE—CON.

**Maine**  
Union Mutual Life Insurance Co.,  
2211 Congress Street, Box 4629, Port-  
land, Maine.

**Maryland**  
Counties of: Montgomery, Prince  
Georges.  
Rest of State: Maryland Medical  
Services, Inc., 700 East Joppa Road,  
Baltimore, Md. 21204.  
Medical Service of D.C., 550 12th  
Street SW., Washington, D.C.  
**Massachusetts**  
Massachusetts Blue Shield, Inc., 133  
Federal Street, Boston, Mass.

**Michigan**  
Michigan Medical Service, 600 Lafayette  
East, Detroit, Mich.

**Minnesota**  
Counties of: Anoka, Dakota, Henne-  
pin, Fillmore, Goodhue, Houston, Ram-  
sey, Washington, Olmsted, Wabasha,  
Winona.  
The Travelers Insurance Co., 8120  
Penn Avenue, South, Bloomington,  
Minn.  
Rest of State: Blue Shield of Minne-  
sota, P.O. Box 7899, Minneapolis, Minn.  
55404.

**Mississippi**  
The Travelers Insurance Co., P.O.  
Box 22543, Jackson, Miss.

**Missouri**  
Counties of: Andrew, Atchison, Bates,  
Benton, Buchanan, Caldwell, Carroll,  
Cass, Clay, Clinton, Davies, De Kalb,  
Gentry, Grundy, Harrison, Henry, Holt,  
Jackson, Johnson, Lafayette, Livingston,  
Mercer, Nodaway, Pettis, Platte, Ray,  
St. Clair, Saline, Vernon, Worth.  
Blue Shield of Kansas City, 3637  
Broadway, P.O. Box 169, Kansas City,  
Mo.  
Rest of State: General American Life  
Insurance Co., P.O. Box 305, St. Louis,  
Mo.

**Montana**  
Montana Physicians Service, P.O.  
Box 2510, Helena, Mont.

**Nebraska**  
Mutual of Omaha Insurance Co., P.O.  
Box 456, Downtown Station, Omaha,  
Neb.  
**Nevada**  
Aetna Life and Casualty, P.O. Box  
3077, Reno, Nev.

PART A—HOSPITAL INSURANCE—CON.

**New Hampshire**  
New Hampshire-Vermont Hospital-  
ization Service, 2 Pillsbury Street,  
Concord, N.H.  
The Travelers Insurance Co.<sup>2</sup>

**New Jersey**  
Hospital Service Plan of New Jersey,  
500 Broad Street, Newark, N.J.  
The Prudential Insurance Co. of New  
Jersey, P.O. Box 6500, Millville, N.J.  
**New Mexico**  
Hospital Service, Inc.; 12500 Indian  
School Road NE., Albuquerque, N. Mex.  
The Travelers Insurance Co.<sup>2</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>

**New York**  
Blue Cross of Northeastern New  
York, Inc., P.O. Box 8650, Albany, N.Y.  
Blue Cross of Western New York,  
Inc., Blue Cross Building, 298 Main  
Street, Buffalo, N.Y.  
Chautauque Region Hospital Service  
Corp., 306 Spring Street, Jamestown,  
N.Y.  
Associated Hospital Service of New  
York; 80 Lexington Avenue, New York,  
N.Y.  
Rochester Hospital Service Associa-  
tion, 41 Chestnut Street, Rochester,  
N.Y.  
Blue Cross of Central New York, Inc.,  
407 South State Street, Syracuse, N.Y.  
Hospital Plan, Inc., 5 Hopper Street,  
Utica, N.Y.  
Hospital Service Corp. of Jefferson  
County, 158 Stone Street, Watertown,  
N.Y.

**New York**  
Aetna Life and Casualty.<sup>1</sup>  
The Travelers Insurance Co.<sup>2</sup>

**North Carolina**  
North Carolina Blue Cross and Blue  
Shield, Inc., 800 South Duke Street,  
Durham, N.C.  
Aetna Life and Casualty.<sup>1</sup>

**North Dakota**  
Blue Cross of North Dakota, 301  
Eighth Street, South, Fargo, N. Dak.  
Aetna Life and Casualty.<sup>1</sup>

PART B—MEDICAL INSURANCE—CON.

**New Hampshire**  
New Hampshire-Vermont Physicians  
Service, 2 Pillsbury Street, Concord,  
N.H.

**New Jersey**  
The Prudential Insurance Co. of  
America, P.O. Box 6500, Millville, N.J.

**New Mexico**  
The Equitable Life Assurance So-  
ciety, P.O. Box 3070, Station D, Al-  
buquerque, N. Mex.

**New York**  
Counties of Bronx, Columbia, Dela-  
ware, Dutchess, Greene Kings, Nassau,  
New York, Orange, Putnam, Richmond,  
Rockland, Suffolk; Sullivan, Ulster,  
and Westchester.  
United Medical Service, Inc., 2 Park  
Avenue, New York, N.Y.  
County of Queens.  
Group Health Inc., 227 West 40th  
Street, New York, N.Y.  
Counties of: Livingston, Monroe,  
Ontario, Seneca, Wayne, Yates.  
Genesee Valley Medical Care, Inc.,  
41 Chestnut Street, Rochester, N.Y.

**North Carolina**  
The Prudential Insurance Co. of  
America, Medicare B, P.O. Box 1482,  
High Point, N.C.

**North Dakota**  
North Dakota Physicians Service, 301  
Eighth Street, South, Fargo, N. Dak.

PART A—HOSPITAL INSURANCE—CON.

**Ohio**  
Blue Cross Hospital Plan, Inc., 201 Ninth Street N.W., Canton, Ohio.  
Hospital Care Corp., 1361 William Howard Taft Road, Cincinnati, Ohio.  
Blue Cross of Northeast Ohio, 2066 East Ninth Street, Cleveland, Ohio.  
Blue Cross of Central Ohio, 174 East Long Street, Columbus, Ohio.  
Hospital Service, Inc., 7 Public Square, Lima, Ohio.  
Blue Cross of Northwest Ohio, P.O. Box 943, Toledo, Ohio.  
Associated Hospital Service, Inc., 2400 Market Street, Youngstown, Ohio.  
Nationwide Mutual Insurance Co., P.O. Box 57, Columbus, Ohio.  
Aetna Life and Casualty.<sup>1</sup>  
Kaiser Foundation Health Plan.<sup>4</sup>

**Oklahoma**  
Group Hospital Service, 1215 South Boulder Avenue, P.O. Box 3283, Tulsa, Okla.  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Oregon**  
Blue Cross of Oregon, 100 S.W. Market Street, P.O. Box 1271, Portland, Oreg.  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Pennsylvania**  
Kaiser Foundation Health Plan.<sup>4</sup>

Blue Cross of Lehigh Valley, 1221 Hamilton Street, Allentown, Pa.  
Capital Blue Cross, 100 Pine Street, Harrisburg, Pa.  
Blue Cross of Greater Philadelphia, 1333 Chestnut Street, Philadelphia, Pa.  
Blue Cross of Western Pennsylvania, One Smithfield Street, Pittsburgh, Pa.  
Blue Cross of Northeastern Pennsylvania, Blue Cross Building, 15 South Franklin Street, Wilkes-Barre, Pa.  
Ince-County Hospitalization Plan, Inc., Foxcroft Square, Jenkintown, Pa.  
The Travelers Insurance Co.<sup>2</sup>

**Rhode Island**  
Hospital Service Corp. of Rhode Island, 444 Westminster Mall, Providence, R.I.  
The Travelers Insurance Co.<sup>2</sup>

**South Carolina**  
Blue Cross of South Carolina, Drawer A, Forest Aeres Branch, 1-20 East at Alpine Road, Columbia, S.C.  
**South Dakota**  
Associated Hospitals Service, Inc., 1622 Pierce Street, Sioux City, Iowa.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>

PART B—MEDICAL INSURANCE—CON.

**Ohio**  
Nationwide Mutual Insurance Co., P.O. Box 57, Columbus, Ohio.

**Oklahoma**  
Aetna Life and Casualty, 7 South Harvey, Oklahoma City, Okla.  
Social and Rehabilitative Services, Oklahoma Department of Institutions, P.O. Box 23352, State Capital Station, Oklahoma City, Okla.

**Oregon**  
Aetna Life and Casualty, 522 Southwest Fifth Street, Portland, Oreg.

**Pennsylvania**  
Pennsylvania Blue Shield, Box 65, Camp Hill, Pa.

**Rhode Island**  
Rhode Island Medical Society Physicians' Service, 444 Westminster Mall, Providence, R.I.

**South Carolina**  
Blue Shield of South Carolina, Drawer F, Forest Aeres Branch, Columbia, S.C.  
**South Dakota**  
South Dakota Medical Service, Inc., 711 North Lake Avenue, Sioux Falls, S. Dak.

PART A—HOSPITAL INSURANCE—CON.

**Tennessee**  
Blue Cross-Rhine Shield of Tennessee, Blue Cross Building, 707 Chestnut Street, Chattanooga, Tenn.  
Memphis Hospital Service and Surgical Association, P.O. Box 98, Memphis, Tenn.  
Aetna Life and Casualty.<sup>1</sup>

**Texas**  
Group Hospital Service, Inc., Blue Cross Building, Main at North Central Expressway, Dallas, Tex.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Utah**  
Blue Cross of Utah, 2455 Parley's Way, P.O. Box 270, Salt Lake City, Utah.  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Vermont**  
New Hampshire-Vermont Hospitalization Service, Two Pillsbury Street, Concord, N.H.  
The Travelers Insurance Co.<sup>2</sup>

**Virginia**  
Blue Cross of Virginia, 2015 Staples Mill Road, Richmond, Va.  
Blue Cross of Southwestern Virginia, 1212 Third Street S.W., P.O. Box 2770, Roanoke, Va.  
Group Hospitalization, Inc., 550 12th Street S.W., Washington, D.C.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Washington**  
Blue Cross Washington-Alaska, Inc., 601 Broadway, P.O. Box 327, Seattle, Wash.  
Aetna Life and Casualty.<sup>1</sup>

**West Virginia**  
Mutual of Omaha Insurance Co.<sup>3</sup>  
Blue Cross Hospital Service, Inc., P.O. Box 1353, Commerce Square, Charleston, W. Va.  
Parkersburg Hospital Service, Inc., 203 Union Trust Building, Parkersburg, W. Va.  
West Virginia Hospital Service, Inc., 21st at Chapline Street, Wheeling, W. Va.  
Mutual of Omaha Insurance Co.<sup>3</sup>

**Wisconsin**  
Associated Hospital Service, Inc., 4115 North Teutonia Avenue, Milwaukee, Wis.  
Aetna Life and Casualty.<sup>1</sup>  
Mutual of Omaha Insurance Co.<sup>3</sup>  
**Wyoming**  
Wyoming Hospital Service, 4020 House Avenue, P.O. Box 2266, Cheyenne, Wyo.

PART B—MEDICAL INSURANCE—CON.

**Tennessee**  
The Equitable Life Assurance Society, P.O. Box 1465, Nashville, Tenn.

**Texas**  
Group Medical and Surgical Service, Blue Cross Building, Main at North Central Expressway, Dallas, Tex.

**Utah**  
Blue Shield of Utah, 2455 Parley's Way, P.O. Box 270, Salt Lake City, Utah.

**Vermont**  
New Hampshire-Vermont Physician Service, Two Pillsbury Street, Concord, N.H.  
Counties of: Arlington, Fairfax, City of: Alexandria.

Medical Service of D.C., 550 12th Street S.W., Washington, D.C.  
Rest of State: The Travelers Insurance Co., P.O. Box 26463, Richmond, Va.

**Washington**  
Washington Physicians' Service, 1800 Terry Avenue, Seattle, Wash.

**West Virginia**  
Nationwide Mutual Insurance Co., P.O. Box 3183, Charleston, W. Va. 25332.

**Wisconsin**  
County of: Milwaukee. Surgical Care, 756 North Milwaukee Street, Milwaukee, Wis.  
Rest of State: Wisconsin Physicians Service, P.O. Box 1787, Madison, Wis.  
**Wyoming**  
The Equitable Life Assurance Society, P.O. Box 628, Cheyenne, Wyo.

PART A—HOSPITAL INSURANCE—CON.

*Puerto Rico*

Blue Cross of Puerto Rico, P.O. Box 4331, San Juan, P.R.  
Cooperativa de Seguros de Vida de Puerto Rico, P.O. Box 3428 G.P.O., San Juan, P.R.

*Virgin Islands*

Cooperativa de Seguros de Vida de Puerto Rico, P.O. Box 3428 G.P.O., San Juan, P.R.

*American Samoa*

Hawaii Medical Service Association, P.O. Box 800, Honolulu, Hawaii.

*Guam*

Hawaii Medical Service Association, P.O. Box 800, Honolulu, Hawaii.

PART B—MEDICAL INSURANCE—CON.

*Puerto Rico*

Seguros de Servicio de Salud de Puerto Rico, G.P.O. Box 3628, Hato Rey, P.R.

*Virgin Islands*

Seguros de Servicio de Salud de Puerto Rico, G.P.O. Box 3628, Hato Rey, P.R.

*American Samoa*

Hawaii Medical Service Association, P.O. Box 800, Honolulu, Hawaii.

*Guam*

Aetna Life and Casualty, Kaulaleolani Building, 116 South King Street, Honolulu, Hawaii.

NOTE: The Blue Cross Association, 840 North Lake Shore Drive, Chicago, Ill., is the contractor for all Blue Cross plans participating in the hospital insurance program. The Aetna Life and Casualty processes claims from providers of services from 25 States; the Travelers Insurance Co. from 15 States; Mutual of Omaha Insurance Co. from 26 States; and the District of Columbia and the Kaiser Foundation Health Plan Inc., 4 States. The main office for each of these companies is listed below:

- 1 Aetna Life and Casualty, 151 Farmington Avenue, Hartford, Conn.
- 2 The Travelers Insurance Co., One Tower Square, Hartford, Conn.
- 3 Mutual of Omaha Insurance Co., Box 400, Des Moines, Iowa.
- 4 Kaiser Foundation Health Plan, Inc., Medicare Liaison Division, room 522, 508 16th St., Oakland, Calif.





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